

FOR STATE
HEALTH DEPT.

M

PLA
4
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. It is designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12510

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12499

1. PLACE OF DEATH
a. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Chesapeake City

c. LENGTH OF STAY IN 16

12 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

Mildred

First

Middle

Last

4. DATE
OF
DEATH

11

6

1961

Month

Day

Year

5. SEX

F

White

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

8

8

19

WIDOWED

DIVORCED

9. AGE (in years
last birthday)

57

Yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Ulcer of stomach with

INTERVAL BETWEEN
ONSET AND DEATH

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Arteriosclerosis General Coronary Occlusion

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m.

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

R.C. Dodson M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

11-6-61

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

11-9-61

22c. NAME OF CEMETERY OR CREMATORI

Moravian Cemetery

22d. LOCATION (City, town, or country)

Lititz, Penna. (State)

23. FUNERAL DIRECTOR

PIPPIN FUNERAL HOME

ADDRESS

Shadyside, Elkton,

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

NOV 9 '61

Arthur S. Thorne

PRINTING

1100

4.5% reduction in 1000 hours

1
FOR STATE
HEALTH DEPT.

12512

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12501

1. PLACE OF DEATH

a. COUNTY

Cecil

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Elkton

c. LENGTH OF STAY IN TB

DOA

DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Union Hospital

MARYLAND

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

11

10

19

61

Month

Day

Year

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

12-16-1903

9. AGE (in years
last birthday)

57

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Months

Days

Hours

Min.

11. IS RESIDENCE
ON A FARM?

YES NO

10a. FATHER'S NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

no

16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes, give number or service)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY

Miner

Coal mining

Va.

U.S.A.

17. INFORMANT

Address

Bertha McCann

Hospital Records Elkton, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

523.0

DUE TO

Conditions, if any, which
gave rise to immediate cause

(b)

caused the underlying
cause last.

(c)

DUE TO

Silicosis

(d)

(e)

(f)

(g)

(h)

(i)

(j)

(k)

(l)

(m)

(n)

(o)

(p)

(q)

(r)

(s)

(t)

(u)

(v)

(w)

(x)

(y)

(z)

(aa)

(bb)

(cc)

(dd)

(ee)

(ff)

(gg)

(hh)

(ii)

(jj)

(kk)

(ll)

(mm)

(nn)

(oo)

(pp)

(qq)

(rr)

(ss)

(tt)

(uu)

(vv)

(ww)

(xx)

(yy)

(zz)

(aa)

(bb)

(cc)

(dd)

(ee)

(ff)

(gg)

(hh)

(ii)

(jj)

(kk)

(ll)

(mm)

(nn)

(oo)

(pp)

(qq)

(rr)

(ss)

(tt)

(uu)

(vv)

(ww)

(xx)

(yy)

(zz)

(aa)

(bb)

(cc)

(dd)

(ee)

(ff)

(gg)

(hh)

(ii)

(jj)

(kk)

(ll)

(mm)

(nn)

(oo)

(pp)

(qq)

(rr)

(ss)

(tt)

(uu)

(vv)

(ww)

(xx)

(yy)

(zz)

(aa)

(bb)

(cc)

(dd)

(ee)

(ff)

(gg)

(hh)

(ii)

(jj)

(kk)

(ll)

(mm)

(nn)

(oo)

(pp)

(qq)

(rr)

(ss)

(tt)

(uu)

(vv)

(ww)

(xx)

(yy)

(zz)

(aa)

(bb)

(cc)

(dd)

(ee)

(ff)

(gg)

(hh)

(ii)

(jj)

(kk)

(ll)

(mm)

(nn)

(oo)

(pp)

(qq)

(rr)

(ss)

(tt)

(uu)

(vv)

(ww)

(xx)

(yy)

(zz)

(aa)

(bb)

(cc)

(dd)

(ee)

(ff)

(gg)

(hh)

(ii)

(jj)

(kk)

(ll)

(mm)

(nn)

(oo)

(pp)

(qq)

(rr)

(ss)

(tt)

(uu)

(vv)

(ww)

(xx)

(yy)

(zz)

(aa)

(bb)

(cc)

(dd)

(ee)

(ff)

(gg)

(hh)

(ii)

(jj)

(kk)

(ll)

(mm)

(nn)

(oo)

(pp)

(qq)

(rr)

(ss)

(tt)

(uu)

(vv)

(ww)

(xx)

(yy)

(zz)

(aa)

(bb)

(cc)

(dd)

(ee)

(ff)

(gg)

(hh)

(ii)

(jj)

(kk)

(ll)

(mm)

(nn)

(oo)

(pp)

(qq)

(rr)

(ss)

(tt)

(uu)

(vv)

(ww)

(xx)

(yy)

(zz)

(aa)

(bb)

(cc)

(dd)

(ee)

(ff)

(gg)

(hh)

(ii)

(jj)

(kk)

(ll)

(mm)

(nn)

(oo)

(pp)

(qq)

(rr)

(ss)

(tt)

100

100

100

100

100 100

100 100

100 100

100 100

100 100

100 100

100 100

100 100

100 100

100 100

100 100

100 100

100 100

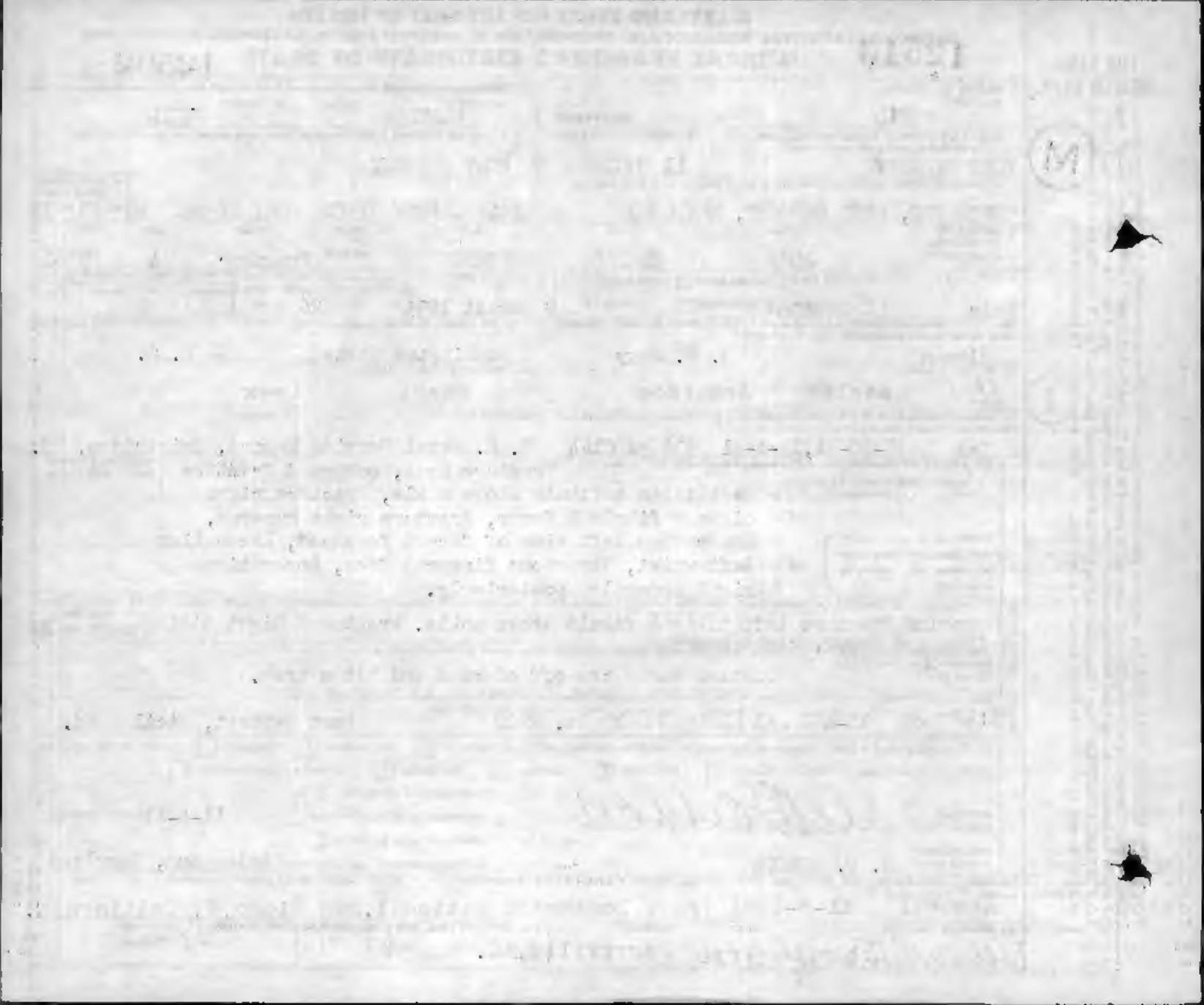
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12513 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12502

To DIVISION OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CECIL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT DEPOSIT		c. LENGTH OF STAY IN lb 11 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT DEPOSIT		d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROUTE 222, PORT DEPOSIT, MARYLAND				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOHN		First	Middle	Last	4. DATE OF DEATH November 4 19 61	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1935		9. AGE (In years last birthday) 26 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radioman		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Washington State		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Dece / Charles Anderson				14. MOTHER'S MAIDEN NAME Hazel Drew					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 7-30-54, 11-4-61 536 32 014		17. INFORMANT U. S. Naval Service Record, Bainbridge, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Fracture neck, compound fracture left tibia & fibula above ankle, Fracture right		INTERVAL BETWEEN ONSET AND DEATH					
823X Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		DUE TO tibia & fibula & femur, Fracture right humerus, (b) Laceration left side of face & forehead, Laceration DUE TO left wrist, Abrasions finger & face, Laceration (c) right upper leg posteriorly.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Compound Fracture left tibia & fibula above ankle. Fractures Right tibia fibula & femur, right humerus.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Station Wagon ran off of road and hit a tree.							
20e. TIME OF INJURY 1:40 P.M. 11-4 1961		20f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. #222	20h. (City or town) Port Deposit, Cecil Md.	(County)	(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				11-4-61 DATE SIGNED					
ACTUAL SIGNATURE <i>R. C. Dodson</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) Rising Sun, Maryland					
EXAMINER'S NAME (Type) R. C. DODSON		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		(State)					
22e. BURIAL, CREMATION, REMOVAL (Specify) Removal		22f. DATE THEREOF 11-6-1961		22g. NAME OF CEMETERY OR CREMATORIUM Fort Rosecrans National San Diego, California.		22h. LOCATION (City, town, or county) Perryville, Md.			
23. FUNERAL DIRECTOR See a. Patterson & Son,		ADDRESS Perryville, Md.		24e. REC'D BY REGISTRAR NOV 7 '61		24f. REGISTRAR'S SIGNATURE Arthur S. Krause			
VS. AFSC SM 9/60				DATE					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12514

CERTIFICATE OF DEATH

12501

1. PLACE OF DEATH
a. COUNTYCecil County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point

MARYLAND

c. LENGTH OF STAY IN 16

15 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

VA Hospital

3. NAME OF
DECEASED
(Type or print)

MICHAEL

J. M

BOYLE

4. SEX

Male

6. COLOR OR RACE

White

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

4-9-90

9. AGE (in years
last birthday)

71 yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

13. FATHER'S NAME

Michael J. Boyle

14. MOTHER'S MAIDEN NAME

Margaret Riedy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

Yes

WWI

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

VA Hospital Records-Perry Point, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Hemorrhage

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

2 days

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES NO

Generalized arteriosclerosis

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
D.M.

the 19

20d. INJURY OCCURRED
White Not White
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I, the physician, attended the deceased from 7-18-46, 19..., to 11-27-61, 19..., and that death occurred 5:10 PM from the causes and on the date stated above.)

22a. SIGNATURE

Omar Allahverdi

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
11-27-6122c. PHYSICIAN'S
NAME (Type)

DHIA ALLAHVERDI, M.D.

22d. ADDRESS
VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

23b. DATE THEREOF

11/28/1961

23c. NAME OF CEMETERY OR CREMATORIUM

Calvary Cemetery

23d. LOCATION (City, town or county)

Pittsburgh, Pa.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Pennington

ADDRESS

Pennington & Son, Havre de Grace, Md.

25a. REC'D BY REGISTRAR

NOV 30 '61

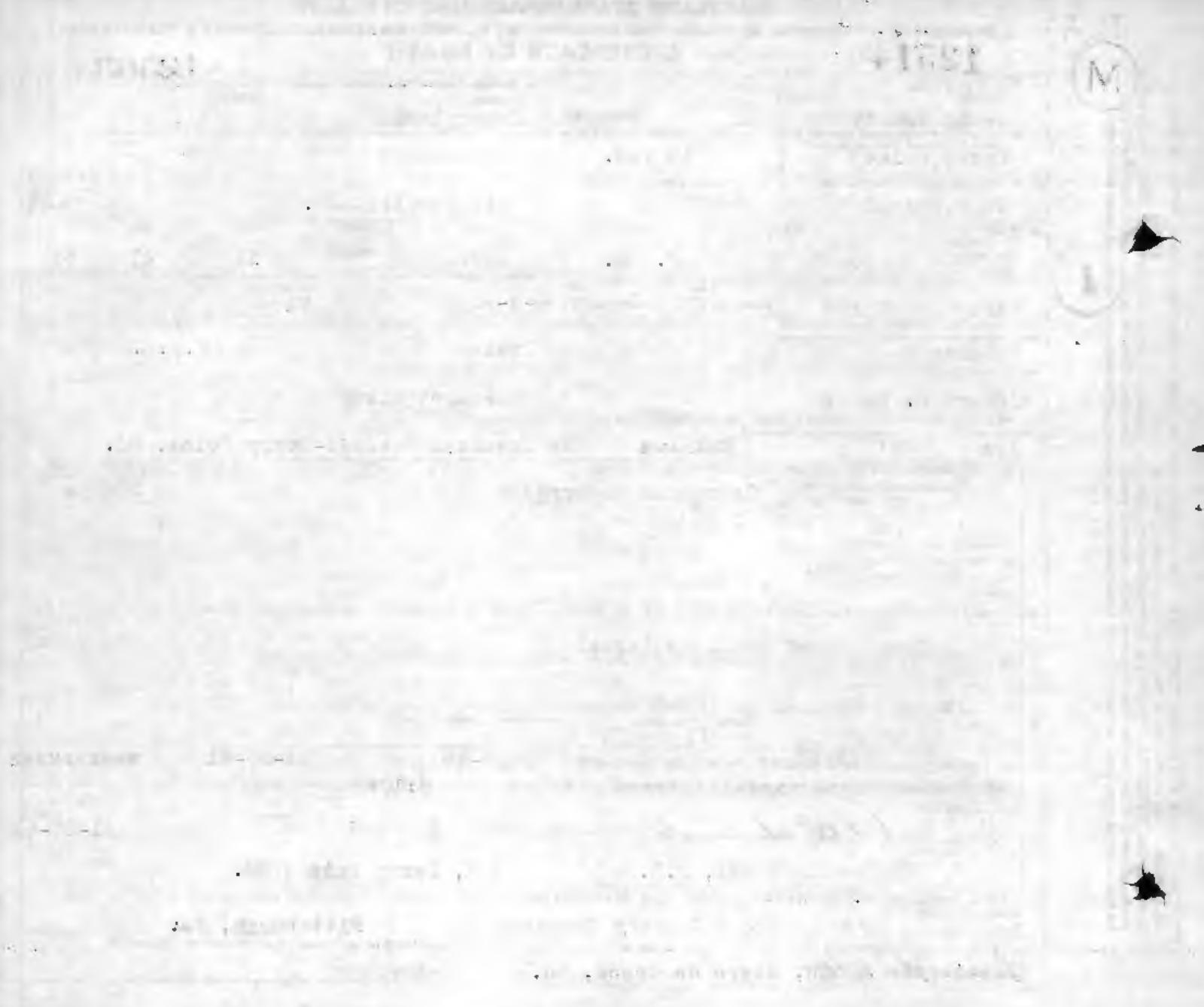
25b. REGISTRAR'S SIGNATURE

Charles L. Harmer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

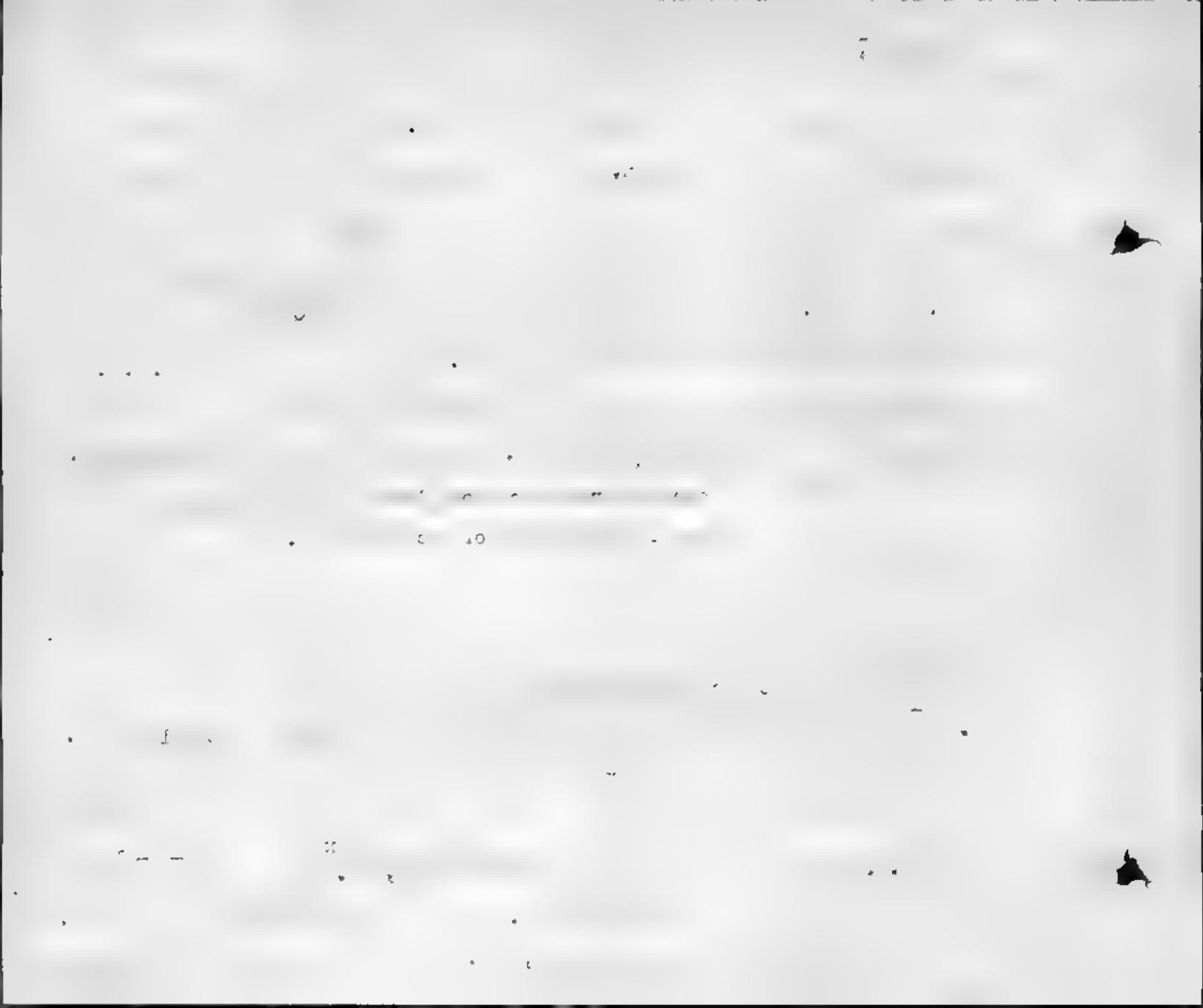
VR AIS 14
15M 7/61



1
FOR STATE
HEALTH DEPT.

1201-1 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)											
	a. STATE Md.		b. COUNTY Cecil		1250-1							
	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ranowingo											
	d. STREET ADDRESS Ranowingo											
	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
	f. DATE OF DEATH 11/22/1961											
	g. AGE (In years last birthday) 20 yrs.											
	h. IF UNDER 1 YEAR Months Days Hours Min.											
	i. IF UNDER 24 HRS Hours Min.											
	j. 12. CITIZEN OF WHAT COUNTRY? U.S.A.											
3. NAME OF (Type or print) Kenneth Edward Brammer												
4. SEX M. W.												
5. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>												
6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>												
7. DATE OF BIRTH 12/22/1940												
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fork Lift Operator												
9. KIND OF BUSINESS OR INDUSTRY Cable Plant												
10. BIRTHPLACE (State or foreign country) Md.												
11. MOTHER'S MAIDEN NAME Blanche Pyle												
12. ADDRESS												
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or date of service) Yes												
14. SOCIAL SECURITY NO. 17 INFORMANT 219 38 5959 Mrs. Blanche Brammer Conowingo, Md.												
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)) Compound Fracture of both lower legs left arm and neck Laceration s of face and nose. INTERVAL BETWEEN ONSET AND DEATH												
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 20. EXTERNAL CAUSE WAS or CONTRIBUTING <input type="checkbox"/>												
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Car collided with tree												
20c. TIME OF INJURY Month Day, Year Hour. Min. 11 22 61 11 25 p.m.												
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) Route 445												
20e. (City or town) (County) (State) Elkton Cecil Md.												
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
22. ACTUAL SIGNATURE R.C. Dodson												
EXAMINER'S NAME (Type) R.C. Dodson												
22a. BURIAL, CREMATION REMOVAL (Specify) Burial												
22b. DATE THEREOF 11/27/61												
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Conowingo Cem.												
22d. LOCATION (City, town or country) Rising Sun, Md.												
23. FUNERAL DIRECTOR John E. McMullan												
24a. REC'D BY REGISTRAR DATE NOV 27 61												
24b. REGISTRAR'S SIGNATURE John E. McMullan												
MEDICAL CERTIFICATION												
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If my delay is necessary, please enclose the certificate, writing the word "Pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be forwarded to the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.												
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal.												
VS. A.I.S.M.E. SM 9/60												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 **M** **12816**

1. PLACE OF DEATH
a. COUNTY **Cecil**

MARYLAND
c. LENGTH OF STAY IN lb **3d 18**

b. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town **Elkton**

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Elkton Hospital of Cecil County**

2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)
e. STATE **Maryland** f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Rural** g. STREET ADDRESS **R. D. 3 Elkton, Md.**

3. NAME OF DECEASED
First **James** Middle **F.** Last **Brown**
Type or print

4. DATE OF DEATH **Nov 29 1961**

5. SEX **Male** **6. COLOR OR RACE** **White** **7. MARRIED** NEVER MARRIED **8. DATE OF BIRTH** **July 15, 1904**

9. AGE (in years) IF UNDER 1 YEAR **69 yrs.** **10. KIND OF BUSINESS OR INDUSTRY** **Self-employed** **11. BIRTHPLACE** **County & State or foreign country** **Virginia**

12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13. FATHER'S NAME **James W. Brown**

14. MOTHER'S MAIDEN NAME **First married Mrs. Taylor**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? **No** **16. SOCIAL SECURITY NO.** **B13-10-2351** **17. INFORMANT** **Mrs. Lucy W. Brown, R. D. 3, Elkton, Md.**

18. CAUSE OF DEATH (Give only one cause per line for a, b, and c)
PART I, DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) **422.1** DUE TO **Myocardial Infarction**
Conditions (any which gave rise to immediate cause) (b) **Hyper tension**
Causes (any which gave rise to conditions) (c) **12 yrs.**

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I **Hyper tension** **20. WAS AN AUTOPSY PERFORMED?** **NO**

20a. ACCIDENT WAS UNDERLYING **20b. DESCRIBE HOW INJURY OCCURRED** Enter nature of injury in Part I or Part II of Item 18
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY **Month** **Day** **Year** **20d. INJURY OCCURRED** **20e. PLACE OF INJURY** **Home** **20f. CITY OR TOWN**
Hour a.m. **pm** **19** **Where** **No where** **factory** **County** **State**
at work **at work**

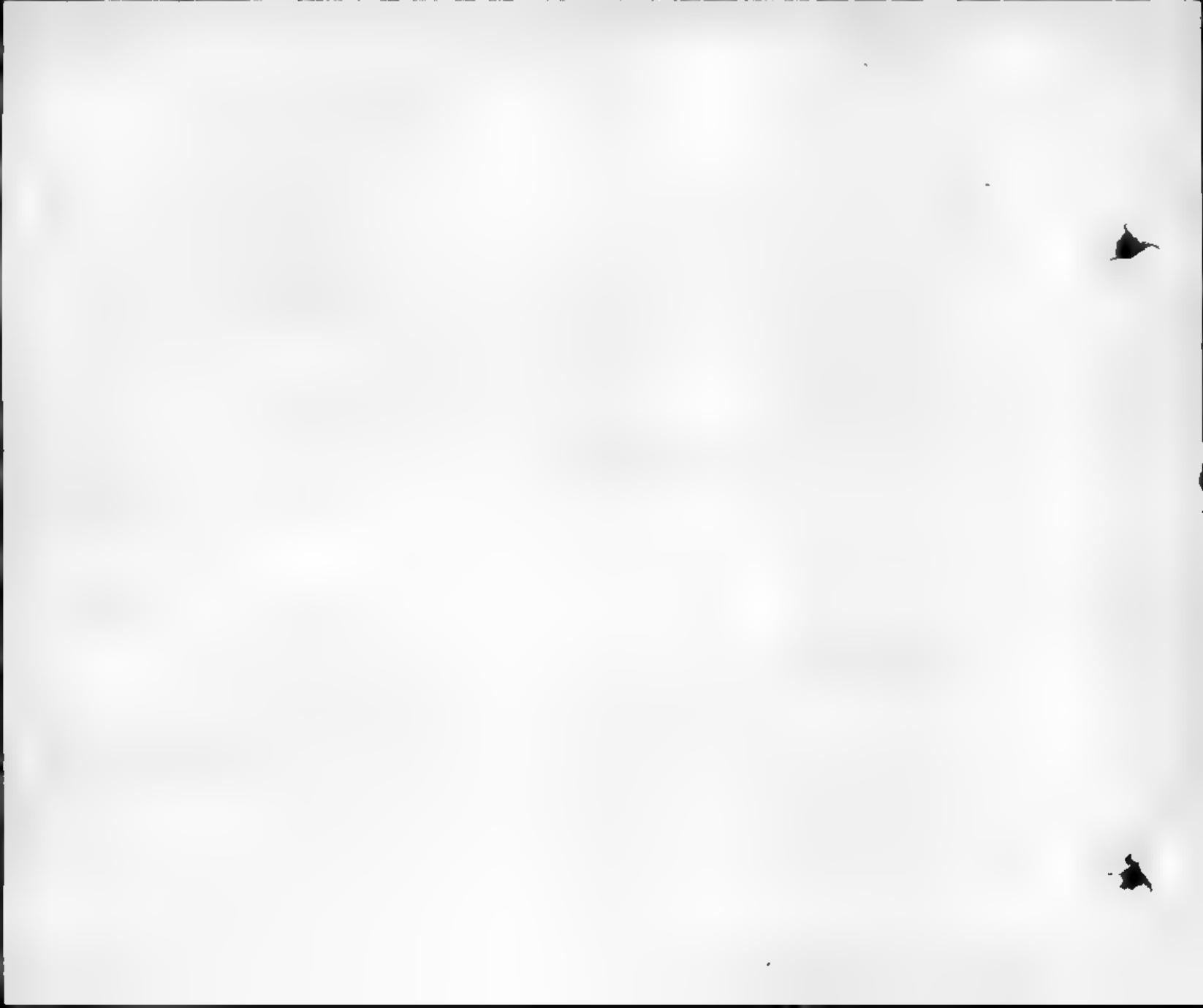
21. I certify that I (this hospital) attended the deceased from **Dec 1960 to Nov 29, 1961**, **that (i) (we) last**
saw the deceased alive on **Nov. 29, 1961**, **and that death occurred at 5 AM**, from the causes and on the date stated above

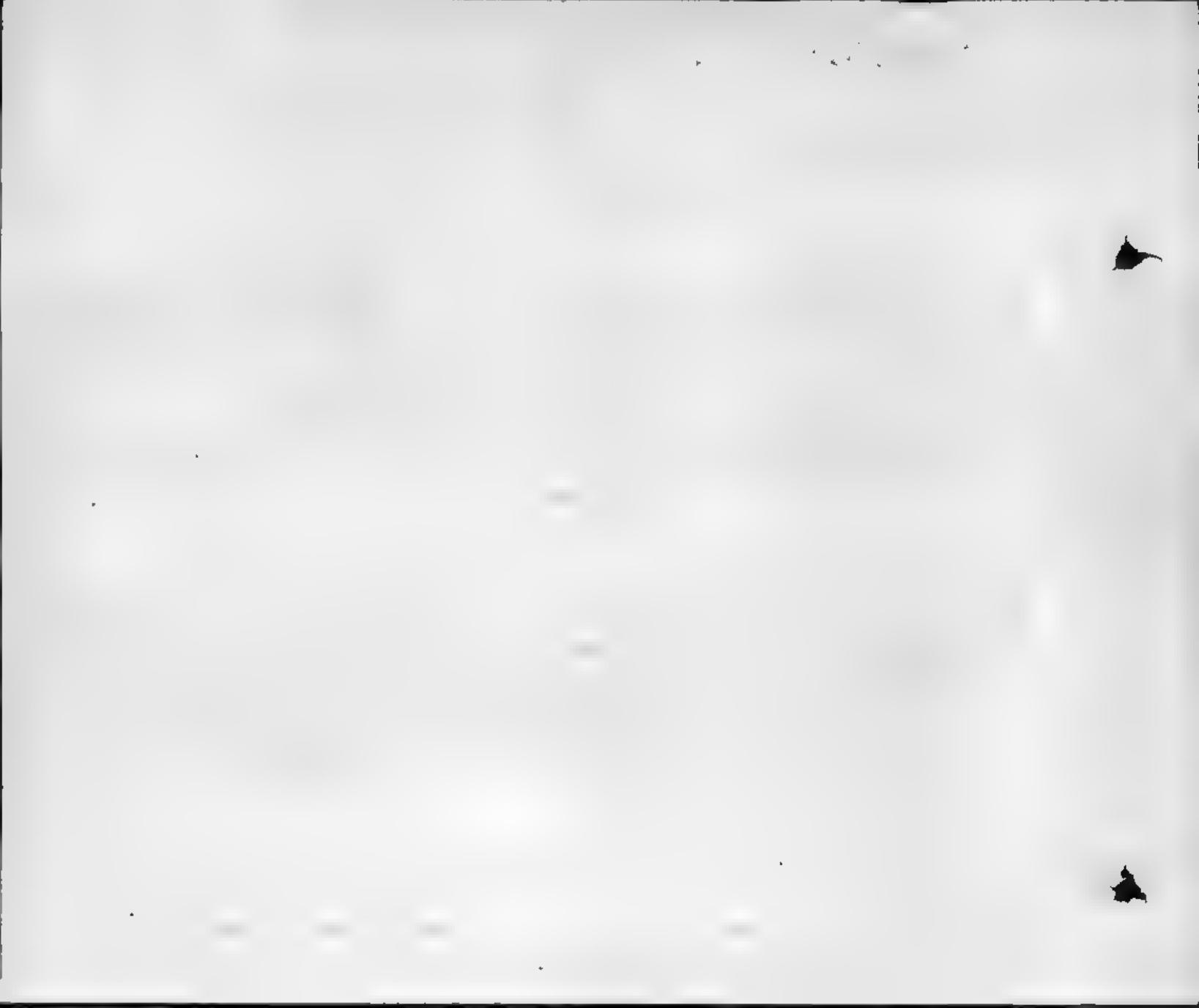
22a. SIGNATURE **Joseph F. Lanz** **22b. DATE SIGNED** **Dec 1961**

22c. ATTENDING PHYS **MED DIRECTOR** **STAFF PHYS**
22d. ADDRESS **22e. Main Street, Elkton, Md.**

23a. BURIAL CREMATION **23b. DATE THEREOF** **23c. NAME OF CEMETERY OR CREMATORIUM** **23d. LOCATION (City, town or county)** **State**
REMOVAL (Specify) **Burial** **Dec 2, 1961** **Gilpin Mortor Corp. Park** **Elkton, Maryland**

24. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** **25a. REC'D BY REGISTRAR** **25b. REGISTRAR'S SIGNATURE**
Ralph E. Hicks **Elkton, Maryland** **DEC 14 1961**





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be signed by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this cert. form has been signed by the attending physician and completely filled in by the funeral director
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death

VS A15 (4)
 15M 9/58

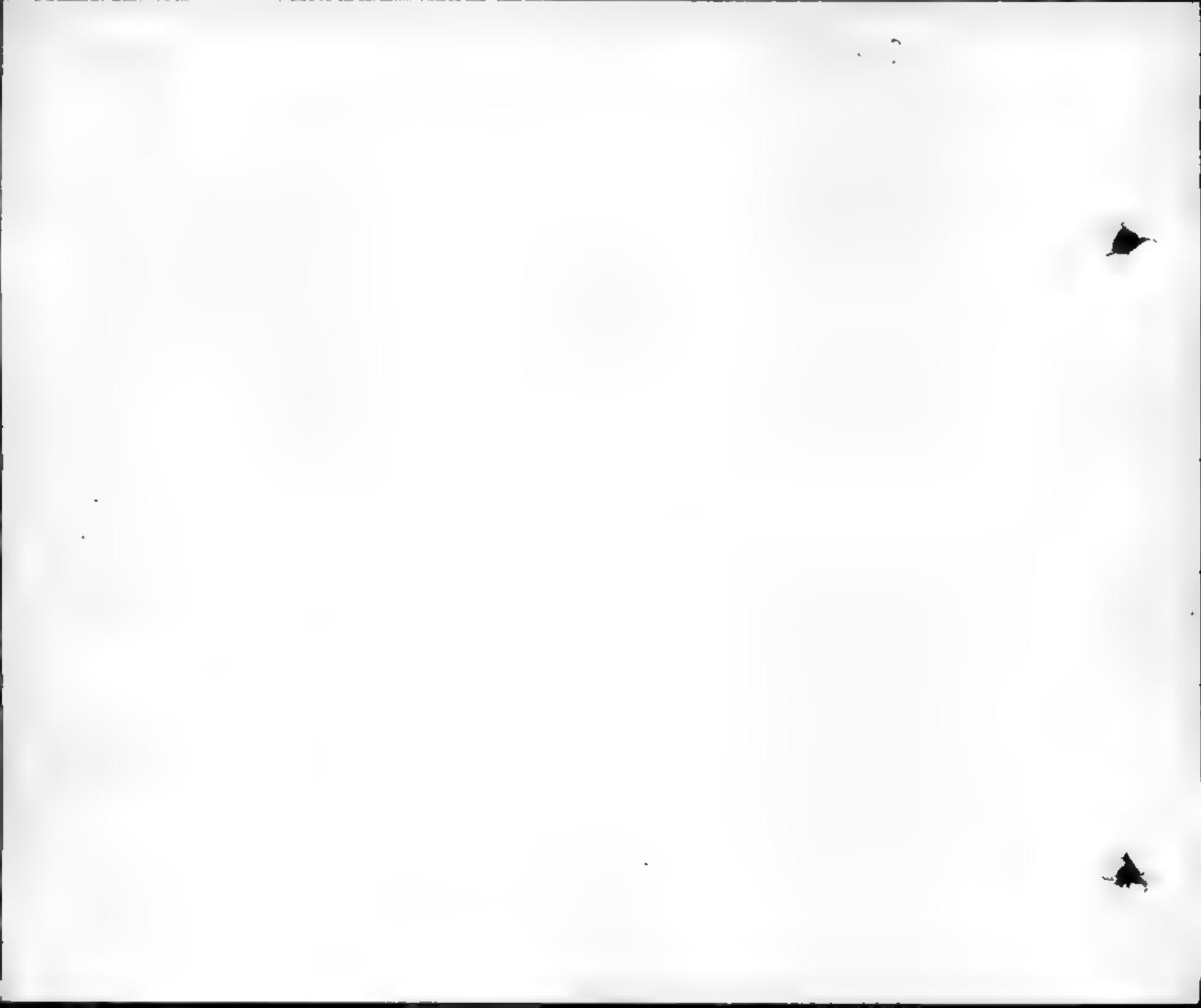
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12518

CERTIFICATE OF DEATH

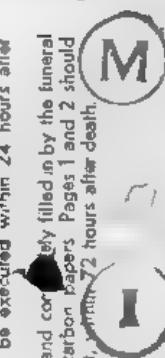
Reg. Dist. 12506

PLACE OF DEATH a. COUNTY CECIL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MD		b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN TB Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P. B. # 71 b. 11		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Elkton Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ellis	Middle W.	Last Ullock	4. DATE OF DEATH	Month NOV.	Day 1,	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1873	9. AGE (In years last birthday) 73 yrs	F. UNDER 1 YEAR Months 0	F. UNDER 24 HRS Days 0	F. UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tipton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ellis W. Ullock		14. MOTHER'S MAIDEN NAME Sarah Jane Ullock					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOC. SEC. NUMBER		INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		Cause of death Congestive Heart Failure and atherosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Pulmonary embolism						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II if item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED Wh. le. Not wh. le. at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory street, office bldg. etc.)		20f. CITY OR TOWN: (County) (State)	
21. I certify that I attended the deceased from 10-27 1961 to 11-1-1961, that I last saw the deceased alive on 11-1-1961, and that death occurred at M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Tillman D. Johnson, M.D.							
PHYSICIAN'S NAME (Type) Tillman D. Johnson, M.D.							
22a. BURIAL CREMATION REMOVAL (Specify) 11/5/61	22b. DATE THEREOF 11/5/61	22c. NAME OF CEMETERY OR CREMATORIAL Tipton, Maryland	22d. LOCATION (City, town or county) Cecil County			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph E. Hicks		ADDRESS Elkton, Maryland		24d. REC'D BY REGISTRAR DATE NOV 8 '61	24e. REGISTRAR'S SIGNATURE Arthur S. Kraus		



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FEDERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12519

CERTIFICATE OF DEATH

12507

PLACE OF DEATH
a. COUNTY

Cecil

MARYLAND

b. LENGTH OF STAY IN 1b

29 days

c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Veterans Administration Hospital

3. NAME OF
DECEASED
Type or print

First Middle
LEWIS (NMI)

4. SEX

6. COLOR OR RACE
7. MARRIED NEVER MARRIED

Male

Negro

WIDOWED DIVORCED

10a. USUAL OCCUPATION Give kind of work
done during mos. of workng life, even if retired)

Chauffeur

10b. KIND OF BUSINESS OR INDUSTRY
Not available

13. FATHER'S NAME

George Carter (deceased)

14. MOTHER'S MAIDEN NAME

Charlotte Lyle (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service)

Yes

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for a, b and c)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Lower nephron nephrosis, cause undetermined

INTERVAL BETWEEN
ONSET AND DEATH

Conditions, if any, which
gave rise to immediate cause
(b), stating the underlying
cause last.

post-operative

19. DUE TO

Right Lower Quadrant sinus tract and
cellulitis of the abdominal wall

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

20. WAS AUTOPSY PERFORMED

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
OR EITHER NOTIFY MEDICAL EXAMINER

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

VA 19

20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of item 2b

20d. INJURY OCCURRED While
at work Not While
at work

20e. PLACE OF INJURY Home farm
factory, street, office bldg., etc

20f. CITY OR TOWN

(County)

State

21. I certify that Stephen A. Hegedus attended the deceased from October 23 1961, to Nov. 21, 1961 ~~at the time of death~~
~~XXXXXX~~ and that death occurred at 10:20 pm M. from the causes and on the date stated above

22e. SIGNATURE

Stephen A. Hegedus

22c. PHYSICIAN'S
NAME (Type)

S. A. HEGEDUS

ATTENDING
M.D. PHYS. MED.
DIRECTOR STAFF
PHYS.

22b. DATE
11-24-61

22d. ADDRESS

V.A. Hospital, Perry Point, Md.

23a. BURIAL OR CREMATION, DATE THEREOF
REMOVAL Specify

11/24/61

23c. NAME OF CEMETERY OR CREMATORIUM

Arlington National

23d. LOCATION (City, town or county)

State

Arlington, Virginia

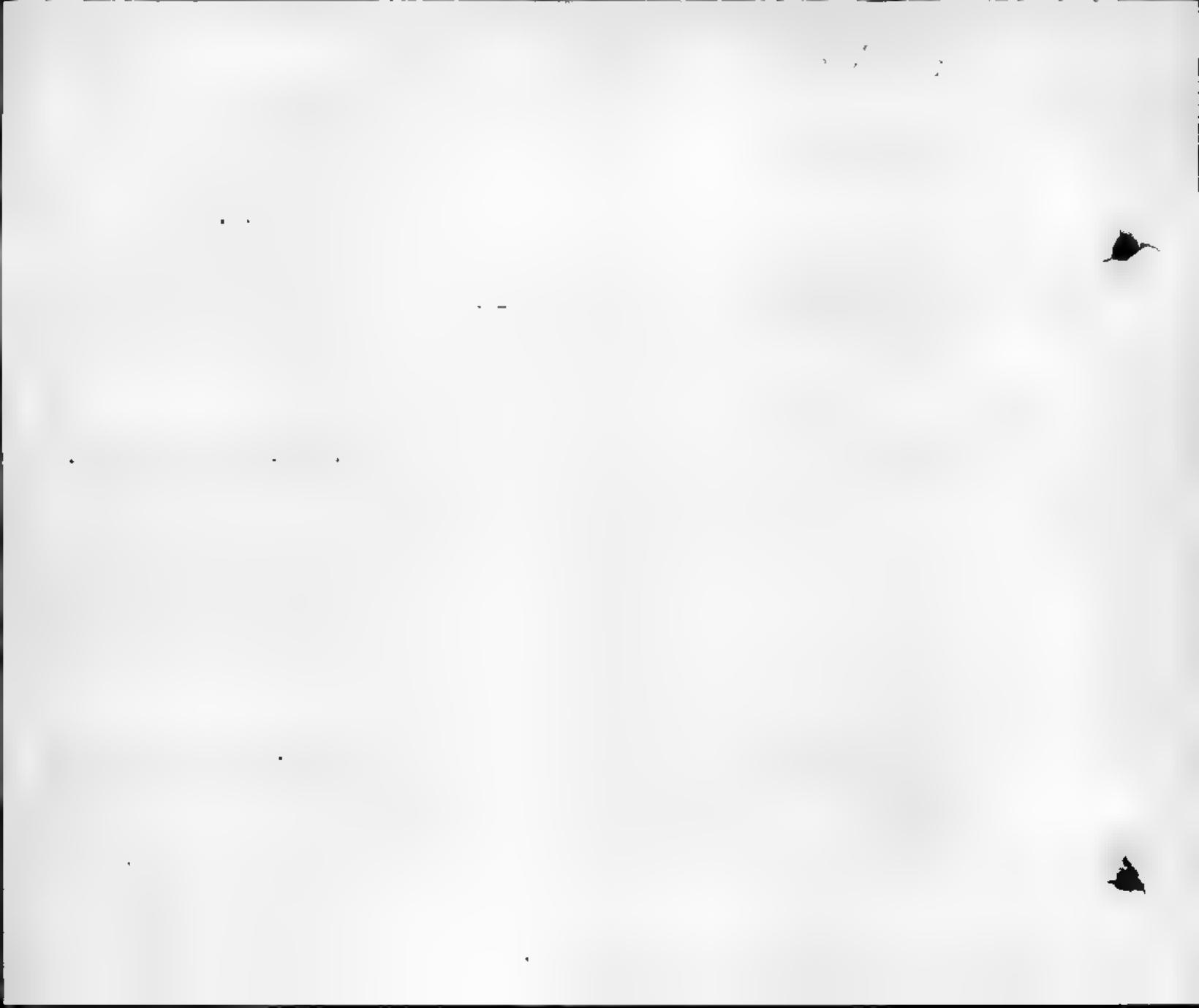
24. FUNERAL DIRECTOR'S SIGNATURE

Stephen A. Hegedus, Havre de Grace, Md.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

NOV 30 '61

Curley S. Krause

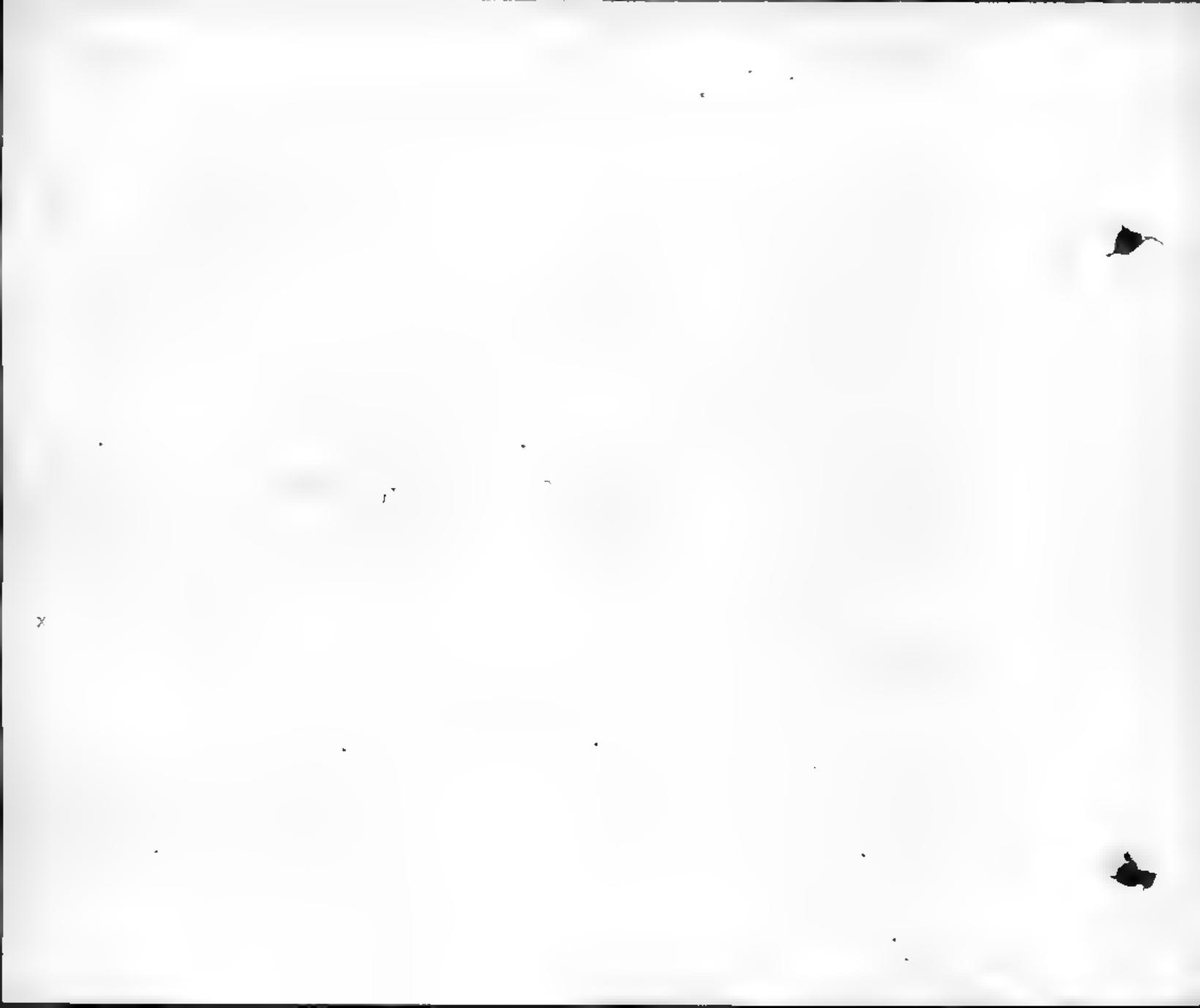


12520

CERTIFICATE OF DEATH

Reg. Dist. 12508

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased resided, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 12 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. STREET ADDRESS Elle Hill		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Mary	Middle Elizabeth	Last Carty	4. DATE OF DEATH Nov. 2, 1961	Month Nov.	Day 2	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1978		9. AGE (In years last birthday) 35 yrs.	FUNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10. US/JAP OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Land		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Turner				14. MOTHER'S MAIDEN NAME Georgianna Kirby				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOC AL SECURITY NO		INFORMANT		Address Mrs. Marguerite Potts, Elkton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with congestive heart failure DUE TO 42.1 INTERVAL BETWEEN ONSET AND DEATH Unknown Cause (b) DUE TO Cause (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Obesity								
20a. ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)	(County)	
21. I certify that I attended the deceased from alive on November 8, 1961		October 30, 1961		5 P.M.	November 9, 1961 that I last saw the deceased M., from the causes and on the date stated above ADDRESS (Street, city or town, state) 233 E. Main Street			
ACTUAL SIGNATURE <i>S. Ralph Andrews, Jr.</i>		M.D.					DATE SIGNED 11/11/61	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D.				Elkton		Maryland		
22a. BUR. A. CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/61		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		22d. LOCATION (City, town or county) Bethel, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph E. Hicks</i>		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR NOV 28 1961		24b. REGISTRAR'S SIGNATURE <i>Caroline L. Thomas</i>		



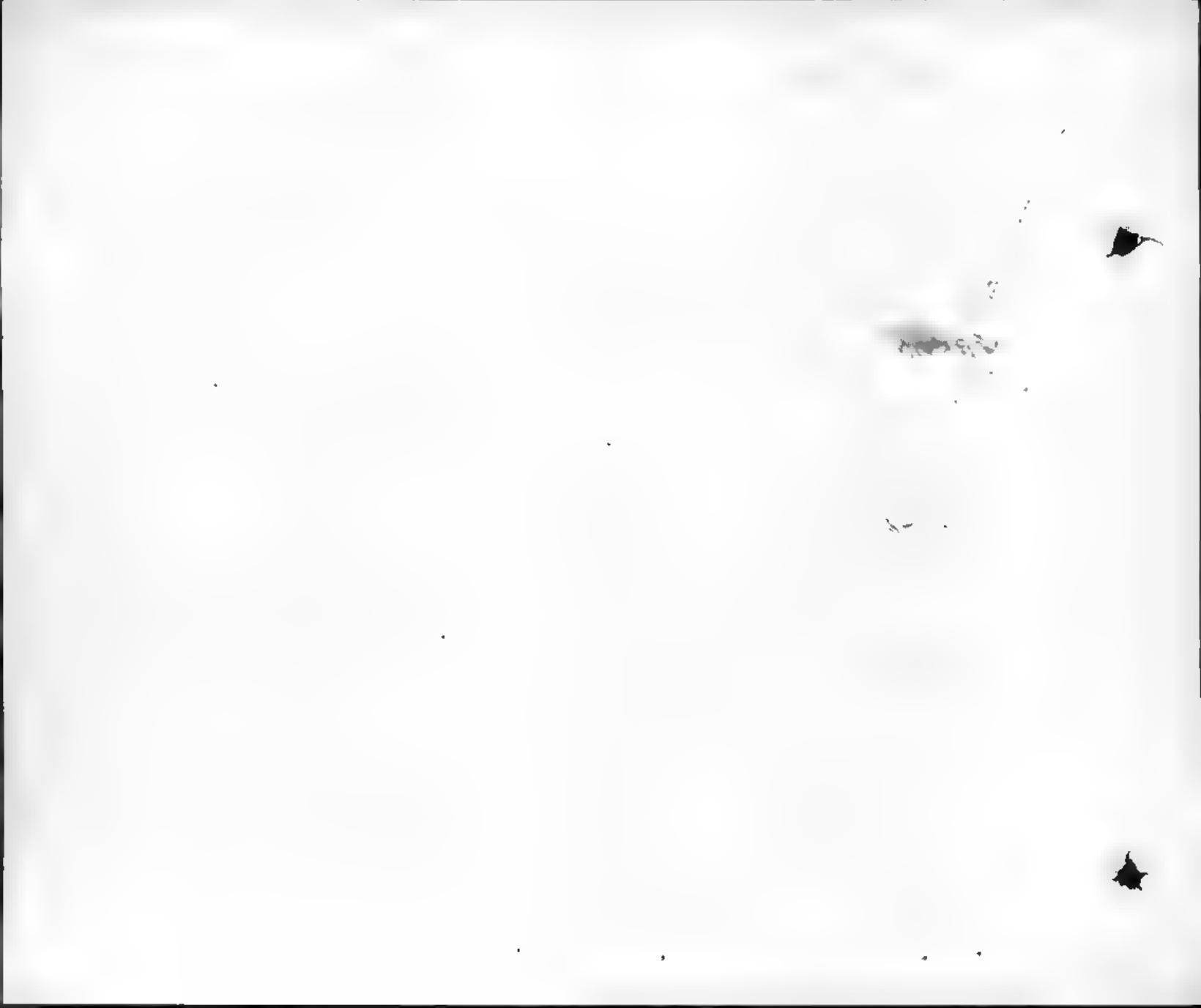
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

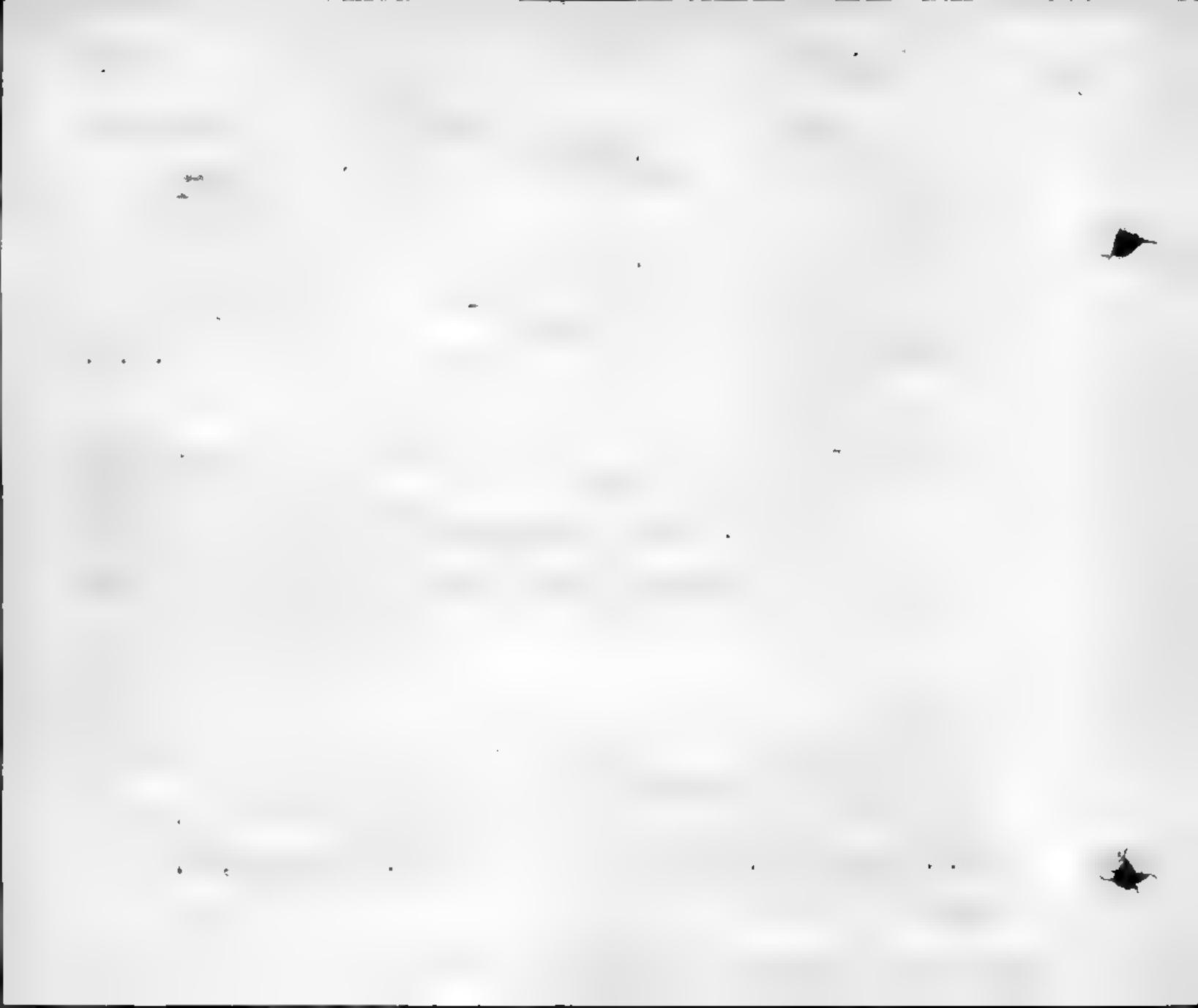
CERTIFICATE OF DEATH

Reg. D 125019

TO HOSPITAL OR ATTENDING PHYSICIAN—The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR—After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial "transit" permit. Then please remove carbon paper. Pages 1 and 2 should be filled in by the registrar prior to burial, removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY CECIL		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission a. STATE MARYLAND		b. COUNTY CECIL							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN		c. LENGTH OF STAY IN 1b 16		c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) RISING SUN		d. STREET ADDRESS 116 BUCKLEY AVENUE							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) NORVAL MILLARD COALE		First	Middle	Last	4. DATE OF DEATH NOV. 20 1961	Month	Day	Year					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 9, 1904		9. AGE (In years at birthday) 57 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 MRS Hours 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLASTERER		10b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR		11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PA		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL T. COALE		14. MOTHER'S MAIDEN NAME CLARA HINDMAN											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 216-07-8801		INFORMANT	Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331 DUE TO Conditions (any which gave rise to immediate cause (a), stating the under- lying cause last) (b) hypertension (c) alcoholism				19. INTERVAL BETWEEN ONSET AND DEATH 2 wks.									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b)	20c. TIME OF INJURY Month Day Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY Home farm factory, street office bldg. etc.	20f. (City or town), (County), (State)
21. I certify that I attended the deceased from 11/2 1961, to 11/20 1961, that I last saw the deceased alive on 11/20 1961, and that death occurred at 11 M from the causes and on the date stated above.									ADDRESS (Street, city or town, state)	DATE SIGNED 11/21/61			
ACTUAL SIGNATURE <i>Neil Taylor Jr</i>		M.D.											
PHYSICIAN'S NAME (Type) Neil Taylor Jr M.D.													
22a. BUR. OR CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 11/24/61	22c. NAME OF CEMETERY OR CREMATORIAL Brookview Cemetery		22d. LOCATION (City, town or county) Rising Sun		(State) Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Read, Rising Sun, Md.		ADDRESS		24a. REC'D. BY REGISTRAR 11/24/61	24b. REGISTRAR'S SIGNATURE C. W. & Hause								
				DATE									





THE BOSTONIAN

LITERATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician. After this certificate has been signed by the attending physician and certified by the medical director, page 3 should be detached for use as the burial-trans 1 permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

12024
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12512

1. PLACE OF DEATH
a. COUNTY

Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.)

Perry Point

MARYLAND

c. LENGTH OF STAY IN lb

6 mo, 15 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Veterans Administration Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

WILLIAM

F.

4. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

11-4-17

Male

White

WIDOWED

9. AGE in years
last birthday

10. DATE
Month November

16

1961

10a. USWAS OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver

Route Man

13. FATHER'S NAME

Henry Eckard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give war record & date of service)

Yes

WW-II

18. INFORMANT

217-03-1164 Hospital Records, VAH, Perry Point, Md.

Address

19. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE -

Acute pulmonary edema, massive

430.0

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first

(b)

Acute congestive heart failure

DUE TO

(c)

Ulcerative bacterial endocarditis, aortic valve 6 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I

19. WAS AN AUTOPSY
PERFORMED?

YES NO

20a. MEDICAL CERTIFICATION

20b. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
IF EITHER NOTIFY MEDICAL EXAMINER

20b. DESCRIBE HOW INJURY OCCURRED (Enter return of injury in Part I or Part II of item 18)

20c. TIME OF INJURY

Month Day Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY

Home Farm

20f. City or town

County

State

Hour

a.m.

p.m.

VA

19

White

Not White

at work

at work

21. I certify that A. L. Mooney attended the deceased from May 1, 1961, to November 10, 1961.

~~XXXXXX~~ and that death occurred at 5:00 A.M. from the causes and on the date stated above

22a. SIGNATURE

A. L. Mooney

22b. DATE SIGNED

11-17-61

23a. BURIAL, CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)

24. FUNERAL DIRECTOR'S SIGNATURE

25a. REC'D BY REGISTRAR

Burke & Son

Havre de Grace, Md.

23c. NAME OF CEMETERY OR CREMATORIUM

New Bridge

ADDRESS

23d. LOCATION (City, town or county)

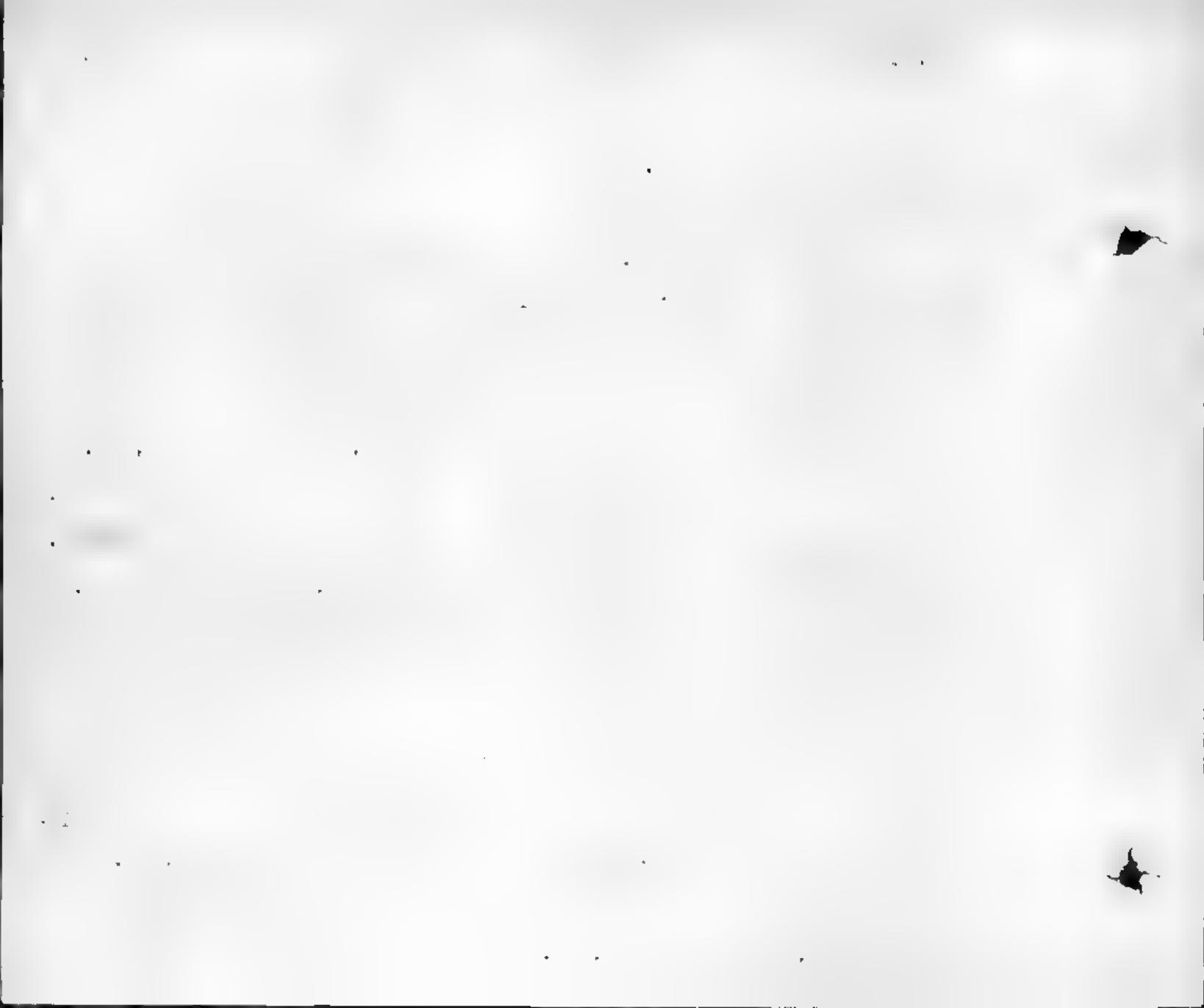
Harrisville, Maryland

State

25b. REGISTRAR'S SIGNATURE

DATE NOV 22 1961

initials & name



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death if possible. If delay is necessary, write the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be filed with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12525

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12513

1. PLACE OF DEATH a. COUNTY Cecil		Item 14 Date 6302 12/18/61 ink		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16		a. STATE Maryland					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		North East Rural		b. COUNTY Cecil					
3. NAME OF DECEASED (Type or print) William		4. DATE OF DEATH Nov. 8 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 23, 1881					
9. AGED (in years last birthday 80 yrs.		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland					
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Foreacre		14. MOTHER'S MAIDEN NAME unknown Goodrow					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary J. Foreacre, North East, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		Acute Coronary		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (c)		INTERVAL BETWEEN ONSET AND DEATH 3 min					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18, White Hot White at work <input type="checkbox"/> at work <input type="checkbox"/>		20c. TIME OF INJURY Month, Day, Year 8 p.m. 11-8-61		20d. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20e. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-8-1961			
ACTUAL SIGNATURE R.C. Dodson		EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 31-12-61		22b. DATE THEREOF 11-12-61		22c. NAME OF CEMETERY OR CREMATORIUM Union Cemetery		22d. LOCATION (City, town or country) North East (Rural, N.R.)			
23. FUNERAL DIRECTOR Joseph R. Grant		ADDRESS 5601 Grant, North East, Maryland		24a. REC'D BY REGISTRAR DATE NOV 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

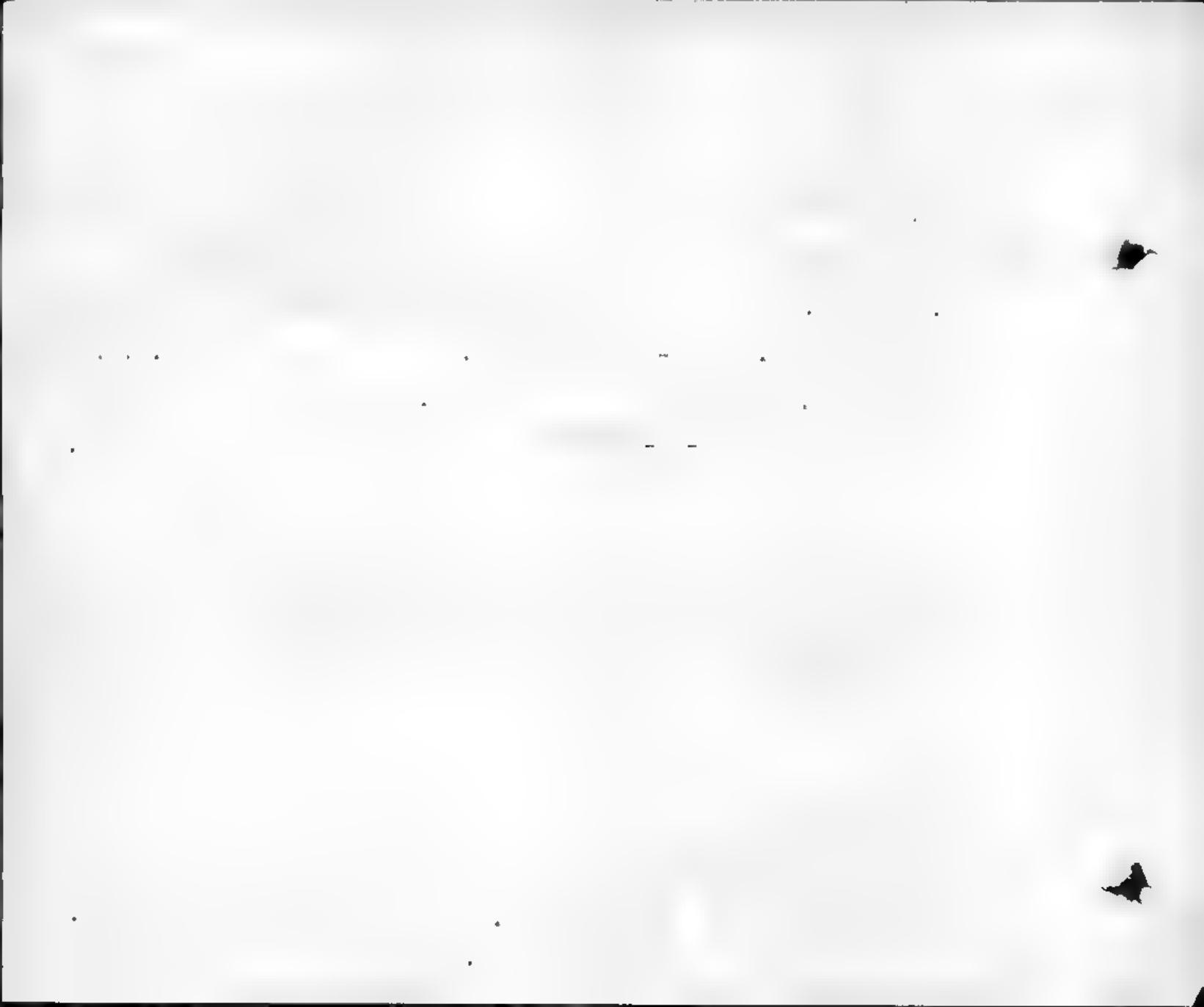


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 (If not signed by the physician or attending physician, the certificate is invalid.)
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST TUT ON UNION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN,	
3. NAME OF DECEASED Type or print) ALICE		d. STREET ADDRESS	
4. SEX F.		5. COLOR OR RACE W.	
6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		7. DATE OF BIRTH 1/10/1885	
10a. OCCUPATION Give kind of work done during most of working life, even if retired) DRESSMAKER		10b. KIND OF BUSINESS OR INDUSTRY RET. SELF-EMPLOYED	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMINE B. GARVIN		14. MOTHER'S MAIDEN NAME SUSAN R. FERGUSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES NO		16. SOC. SEC. NUMBER 7. INFORMANT 212-20-8320A Miss ANNA GARVIN	
17. INTERVAL BETWEEN ONSET AND DEATH 1 week		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a). DUE TO Conditions if any which gave rise to immediate cause (a) stating the under lying cause (b). DUE TO Conditions if any which gave rise to immediate cause (b) stating the under lying cause (c). DUE TO		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18, OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month Day Year Hour a.m. 19 p.m.		20b. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> or work <input type="checkbox"/> of work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, 20f. City or town, factory, street, office, bldg., etc.)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from . . . 10-25-1961 to . . . 11-8-1961 that (I) (we) last saw the deceased alive on 11-7-1961 and that death occurred at 10AM from the causes and on the date stated above		22b. DATE SIGNED	
22a. SIGNATURE Williford Eppes		22b. ADDRESS Hillside & Dalton Rds Newark, Del	
22c. PHYSICIAN'S NAME Williford Eppes, M.D.		22d. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL CREMATION REMOVAL (Specify) Burial 11/11/1961		23c. NAME OF CEMETERY OR CEMETORY BROOKVIEW CEM.	
24. FUNERAL DIRECTOR'S SIGNATURE Vernon E. M. Miller		23d. LOCATION (City, town, or county) (State) RISING SUN MD.	
25a. REC'D. BY REGISTRAR DATE NOV 13 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



15

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12527

CERTIFICATE OF DEATH

12515

1. PLACE OF DEATH
a. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Perry Point

c. LENGTH OF STAY IN 16

lyr. 7 mo. 20 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Veterans Administration Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle Last

JAMES

L.

GORRELL

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED DIVORCED

9-11-90

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

Farming

Maryland

13. FATHER'S NAME

Joseph Gorrell

Evelyn Nesbitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes, give rank or date of service) 212-12-4104

Yes

WW-I

unknown

Hospital Records, VAH, Perry Point, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY

IMMED AYE CAUSE (a)

Arteriosclerotic heart disease with myocardial

420.0

DUE TO infarction

INTERVAL BETWEEN
ONSET AND DEATH

Conditions, if any, which

gave rise to immediate cause

{ (b), stating the underlying

cause last

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY

Arteriosclerosis, generalized. Gangrene, right foot. Chronic

PERFORMED? YES NO

20n. ACCIDENT WAS UNDERLYING] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II)

OR CONTRIBUTING CAUSE OF DEATH

IF EITHER, NOT BY MEDICAL EXAMINER

Brain syndrome

YES NO

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Hour a.m.

VA 19

White Not White at work at work

(County)

State

21. I certify that S. GOLDGRABEN attended the deceased from March 31, 1960, to Nov. 20, 1961, and that death occurred at 11:45 P.M. on the causes and on the date stated above.

22a. SIGNATURE

S. GOLDGRABEN

M.D.

ATTENDING
PHYSMED
DIRECTORSTAFF
PHYS22b. DATE
SIGNED
11-20-61

22c. PHYSICIAN'S

NAME (Type)

S. GOLDGRABEN, Chief, Medical Service, VAH, Perry Point, Md.

23a. BURIAL, CREMATION OR REMOVAL SPECIES

Burial

23b. DATE THEREOF

11/23/1961

23c. NAME OF CEMETERY OR CREMATORIAL

West Nottingham Cemetery

23d. LOCATION (City, town or county)

State

24. FUNERAL DIRECTOR'S SIGNATURE

Ralph Reed

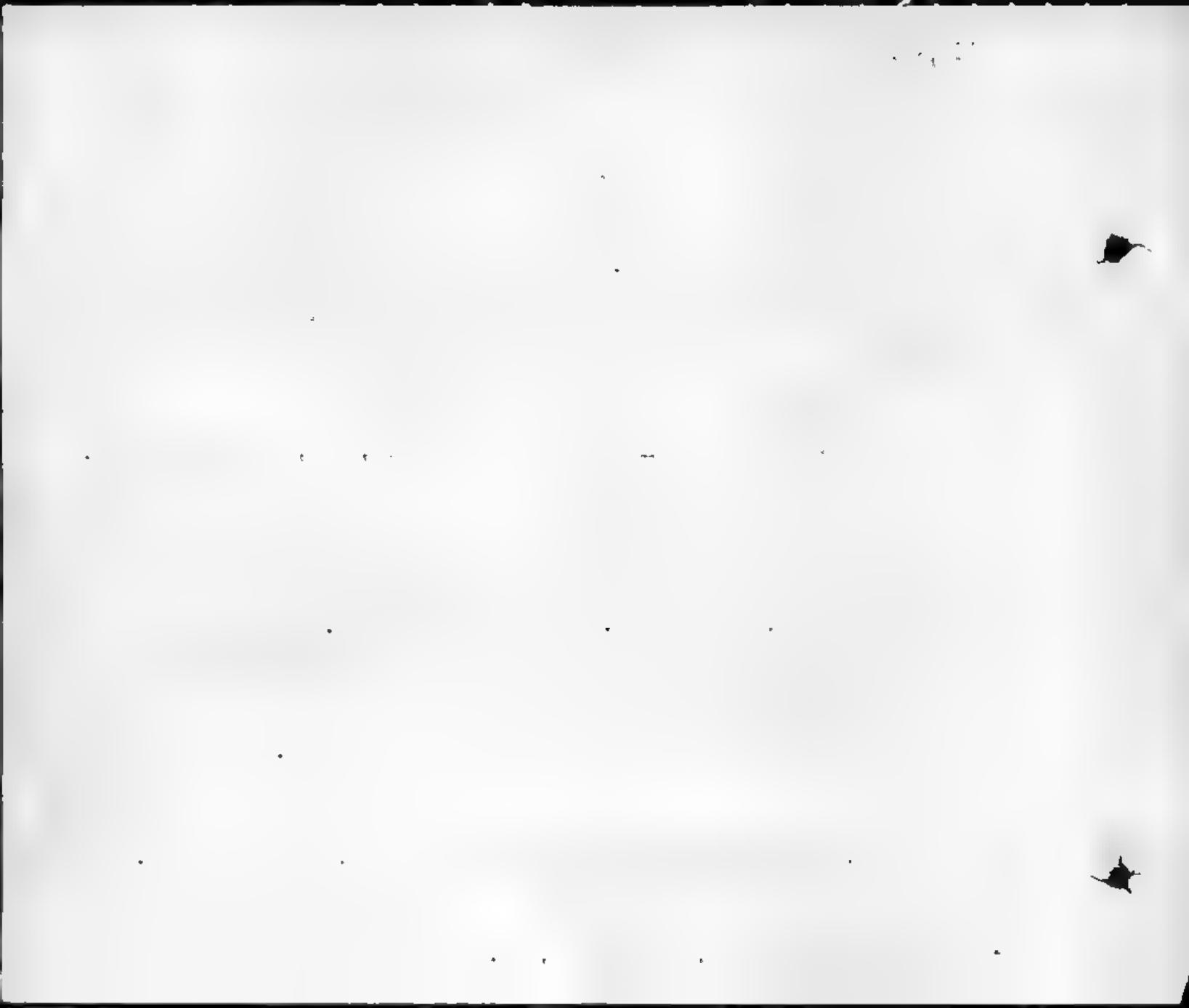
ADDRESS

25a. REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE NOV 24 '61

C. Gold & Krause



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12528

12516

PLACE OF DEATH
o. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN If outside corporate limits write RURAL and give nearest town)

Rising Sun Rural

c. LENGTH OF STAY IN b.

2 yrs.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission
o. STATE

Md.

b. COUNTY

Cecil

c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)

X Rising Sun

Rural

d. STREET ADDRESS

e. S. RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First Middle

Last

4. DATE
OF
DEATH

Month Day Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
1st birthday)
yrs

10. FUNDER 1 YEAR IF UNDER 24 HRS

Male

White

WIDOWED DIVORCED

12/24/1886

74

11 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)

Machine Operator Ret. Fiber Mill

Md.

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

William Hall

Susan Davidson

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

No,

16. SOCIAL SECURITY NO.

221-07-8256

17. INFORMANT

Mr. Paul Hall

Rising Sun, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

DUE TO

Conditions if any, which
gave rise to immediate
cause for stating the under-
lying cause only

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH
days.

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

d. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATE

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month Day Year
Hour a. m. 19 p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm
factory, street, office bldg. etc)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Oct 2 1961 to Nov 3 1961 that (I) (we) last
saw the deceased alive on Nov 2 1961 and that death occurred at 3:30 p.m. from the causes and on the date stated above

22a. SIGNATURES

22c. PHYSICIAN'S
NAME (Type)

G. H. Richards Jr.

M.D. ATTENDING
PHYSMED
D. DIRECTORSTAFF
PHYS

22d. ADDRESS

22b. DATE
SIGNED
12/11/6123a. BURIAL CREMATION
REMOVAL (Specify)

Burial

12/2/1961

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

West Nottingham Cem.

23d. LOCATION City, town, or county

Colora

State

Md.

24. MEDICAL DIRECTOR'S SIGNATURE

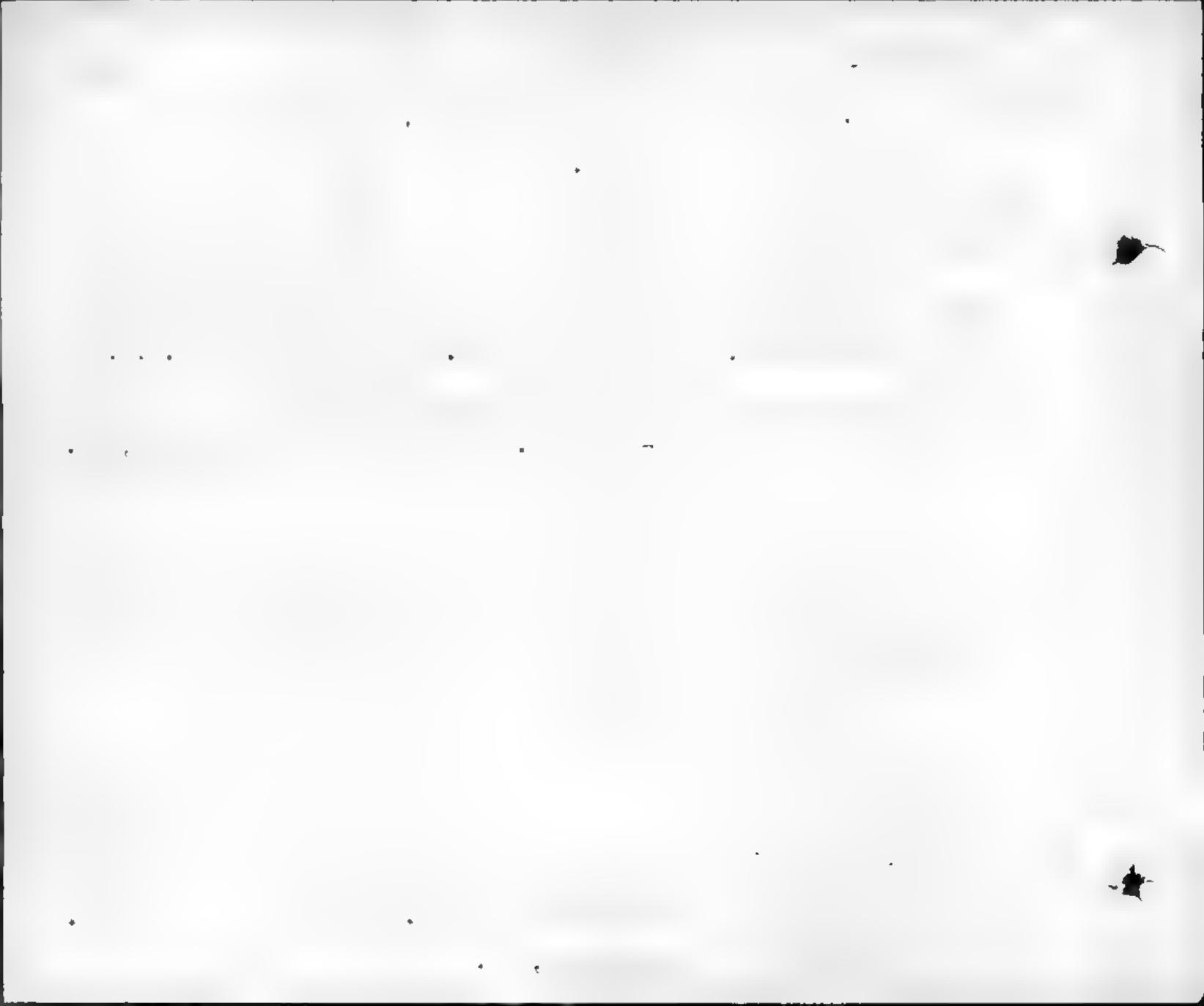
Lemon E. McMillan

25a. REC'D BY REGISTRAR

DEC 4 '61

25b. REGISTRAR'S SIGNATURE

Olive E. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12521 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12517

1
FOR STATE
HEALTH DEPT.

TO SENIORITY MEDICAL EXAMINER This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATISME
SM 9 60

1. PLACE OF DEATH
a. COUNTY

Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural North East

c. LENGTH OF STAY IN TB

MARYLAND

Lifetime

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural North East

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF

First

Middle

Last

4. DATE
OF
DEATHMonth
NovemberDay
3
1961

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

male

white

WIDOWED

DIVORCED

12-16-1978

9. AGE
in years
Last birthday
82
yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE State or foreign country

Retired Auditor and High School Teacher

Maryland

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

J. Wesley Hamilton

Ann Maria Mullen

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unknown. If yes, give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

221-03-7666

Address

G. Page Hamilton

North East, Maryland

INTERVAL BETWEEN
ONSET AND DEATH

5 m in

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE

DUE TO

420.1

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

b)

DUE TO

c)

Acute Coronary

Arterio Sclerotic

Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e.g., 19. WAS AUTOPSY
PERFORMED?YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month Day Year
Hour a.m.
p.m.

20d. INJURY OCCURRED

White

Not White

at work

at work

20e. PLACE OF INJURY (Home, farm
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Indetermined manner ACTUAL
SIGNATURE

NAME (Type)

R.C. Dodson

CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

11-4-1961

22a. BURIAL CREMATION
REMOVAL Specify

22b. DATE THEREOF

23. FUNERAL DIRECTOR

22c. NAME OF CEMETERY OR CREMATORI

ADDRESS

Methodist

22d. LOCATION (City, town or county)

(State)

North East Cecil Co., Md

24a. REC'D BY REGISTRAR

DATE

NOV 9 '61

24b. REGISTRAR'S SIGNATURE

John S. Thomas



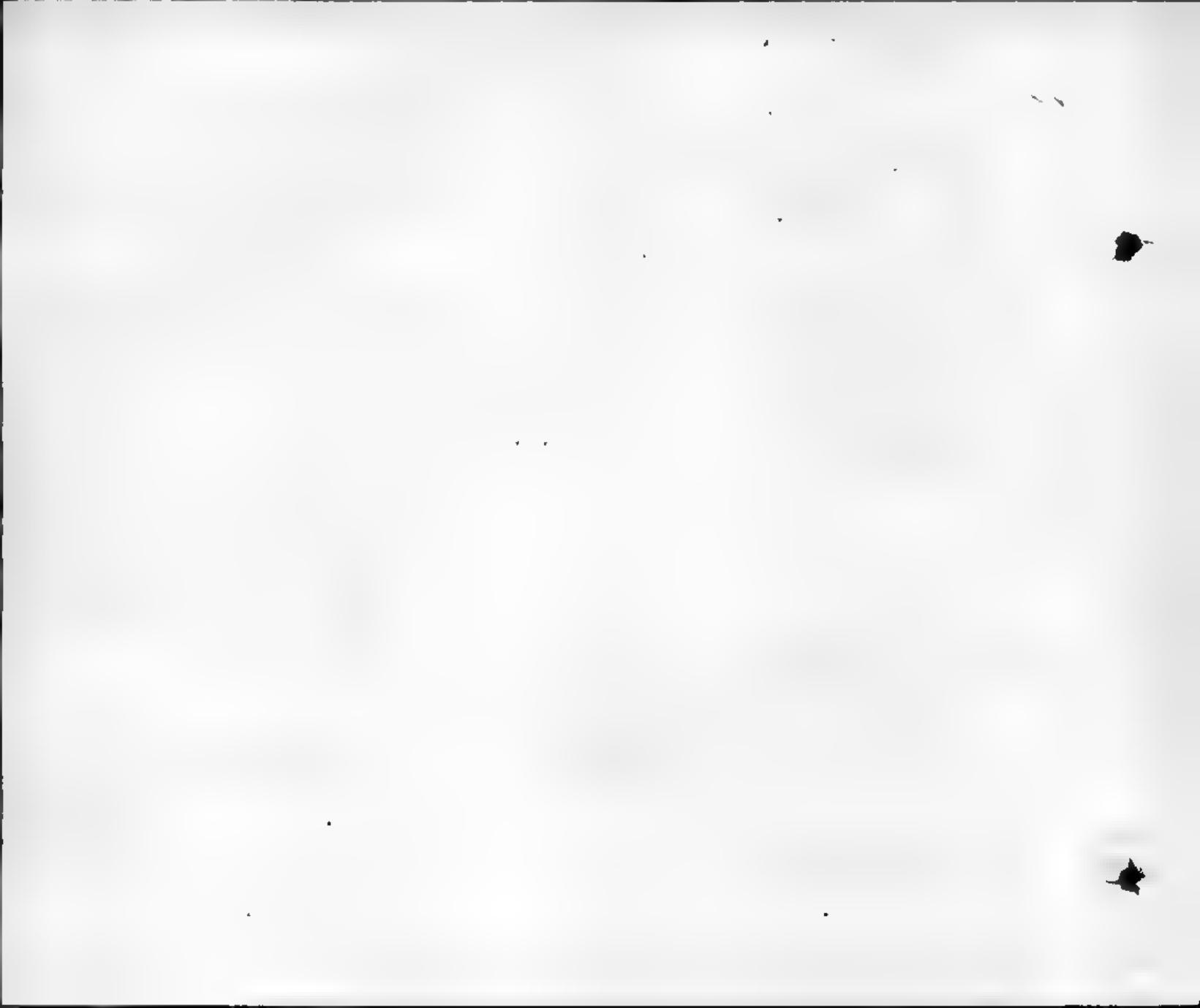
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12530

CERTIFICATE OF DEATH

Reg. Dist. No. 12518

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <u>Delaware</u> b. COUNTY <u>New Castle</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u>		d. STREET ADDRESS <u>1344 Reed Street</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. S. RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>James A. Howell</u>		First	Middle	Last	4. DATE OF DEATH <u>Nov. 25, 1961</u>	Month	Day	Year		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1902</u>	9. AGE (In years last birthday) <u>59</u> yr	FUNDER 1 YEAR IF UNDER 24 HRS					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>				
13. FATHER'S NAME <u>No record</u>				14. MOTHER'S MAIDEN NAME <u>No record</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>222-09-4315</u>		17. INFORMANT <u>A.W. Howell</u>		Address <u>Christiana, Del.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost (b) <u>Arteriosclerotic coronary artery</u> <u>rank</u> DUE TO (c) <u>Generalized arteriosclerosis</u> <u>rank</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-25-1961</u> to <u>11-25-1961</u> that I last saw the deceased alive on <u>11-25-1961</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED										
ACTUAL SIGNATURE <u>Williford Epps</u>		Dallam Rd. Newark, Delaware								
PHYSICIAN'S NAME (Type) <u>Williford Epps</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 29, 1961</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Bethel Cem.</u>		22d. LOCATION (City, town, or county) <u>Bethel, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.T. Jones</u>		ADDRESS <u>Rehoboth, Del.</u>		24a. REC'D BY REGISTRAR DATE <u>Dec 5 '61</u>			24b. REGISTRAR'S SIGNATURE <u>John S. Jones</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4
 to be held by the hospital or attending physician
 TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician on and completed by the funeral director
 page 3 should be detached for use as the burial permit. Then please remove carbon paper
 the registrar prior to burial or removal and in any event within 72 hours after death.



65

12531

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 item 9 Film G302 12-8-61 1wk
 CERTIFICATE OF DEATH

Reg. Dist. 12519

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE Where deceased lived 1. institution Residence before admission a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Add'l Elkhon		c. LENGTH OF STAY (In lb) 8 d	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elkhon	
3. NAME OF DECEASED (Type or print) Anna		4. DATE OF DEATH Nov 23 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Oak Grove, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lucas Kelley		14. MOTHER'S MAIDEN NAME Maude Towers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown No		16. SOCIAL SECURITY NO. INFORMANT George B. Johnson	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 175.0 DUE TO Conditions if any which gave rise to immediate cause (a), stating the under- lying cause first		18. DATE OF INJURY 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 14 d 6 mos Year	
b) Metastatic carcinoma DUE TO c) Carcinoma, ovary			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART NO. 18			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either not by medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Hour a.m. p.m.	Month 9	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home farm 20f (City or town) factory street office bldg etc., (County) (State)
21. I certify that I attended the deceased from March 14-23, 1961, and that death occurred at 11:21 P.M. from the causes and on the date stated above. actual signature Tillman D. Johnson		ADDRESS (Street, city or town, state) 173 S. 5th St. Elkhon, Md. DATE SIGNED 11-23-61	
22a. BURIAL CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-27-61	22c. NAME OF CEMETERY OR CREMATORIUM RIVERVIEW CEMETERY
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. Harrington - Wilmer, Del.		22d. LOCATION (City, town, or county) WILMINGTON, DEL.	
ADDRESS		24a. REC'D BY REGISTRAR NOV 29 '61	24b. REGISTRAR'S SIGNATURE W. M. Harrington

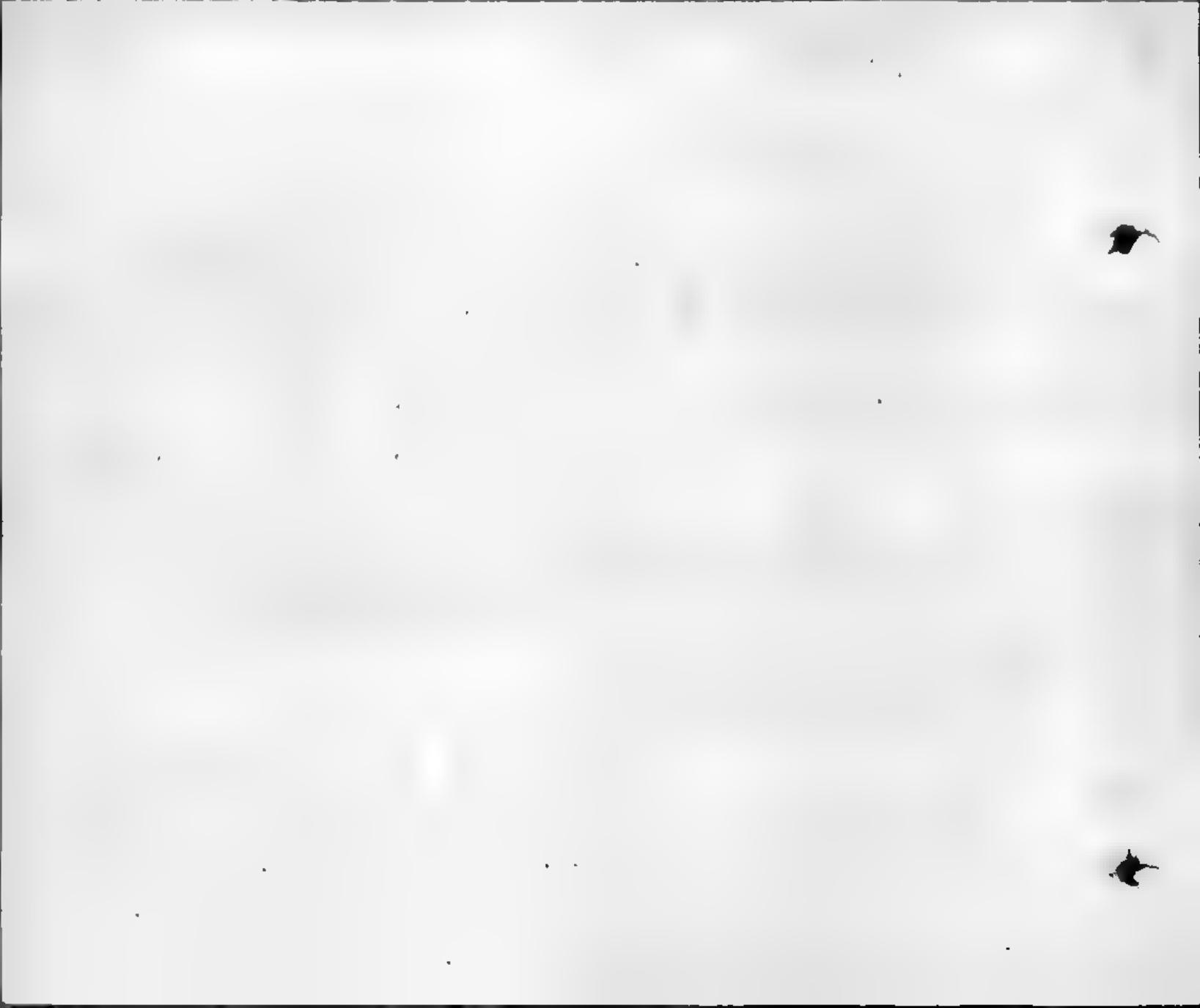


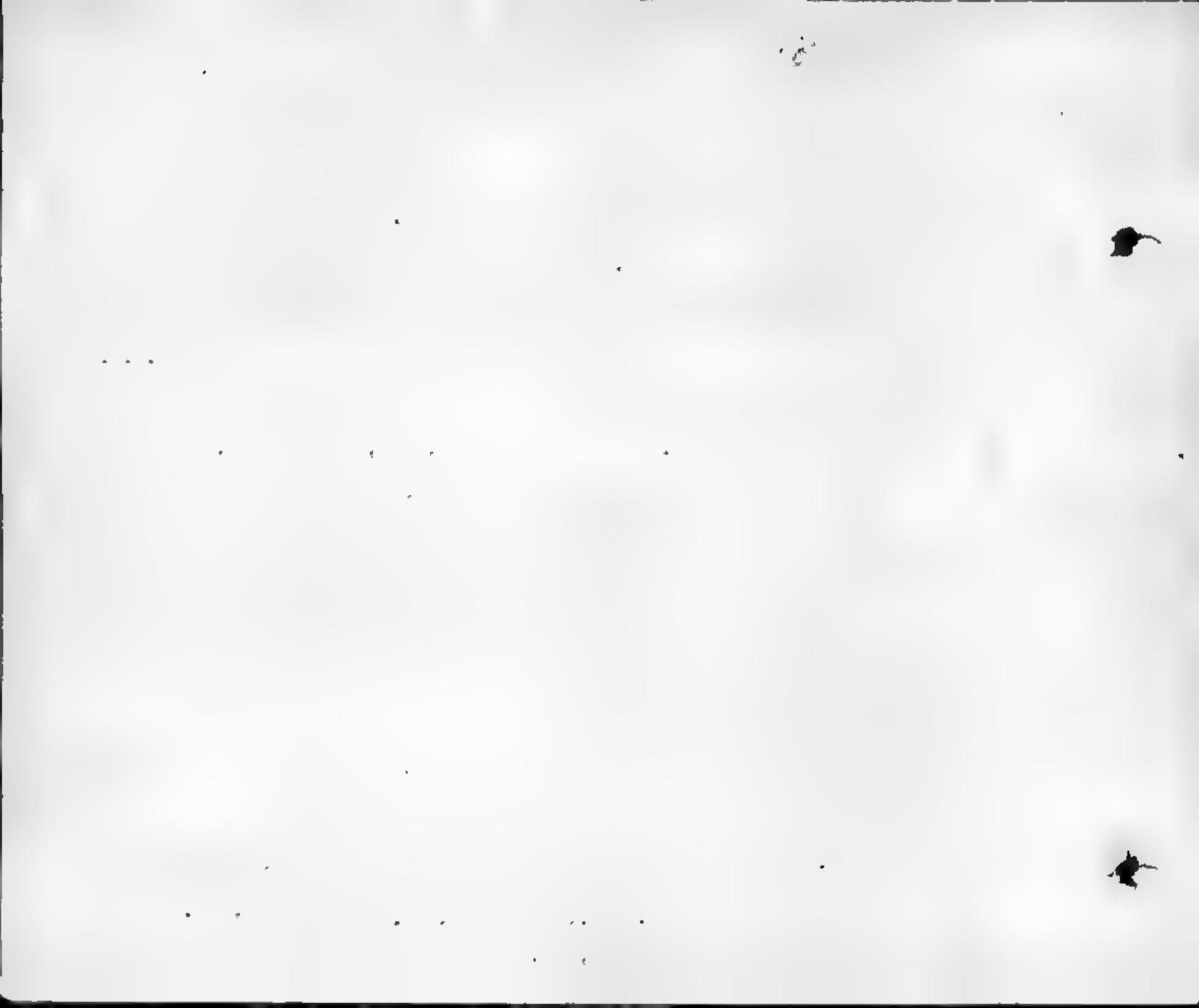
Herbert W. Huntington
c/o Marshall H. P. Ward & Son,
Funeral Directors
819 Washington St.
Wilmington, Del.

Mr. F.

1000

Clear





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12534

CERTIFICATE OF DEATH

Reg. No. 10-522

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

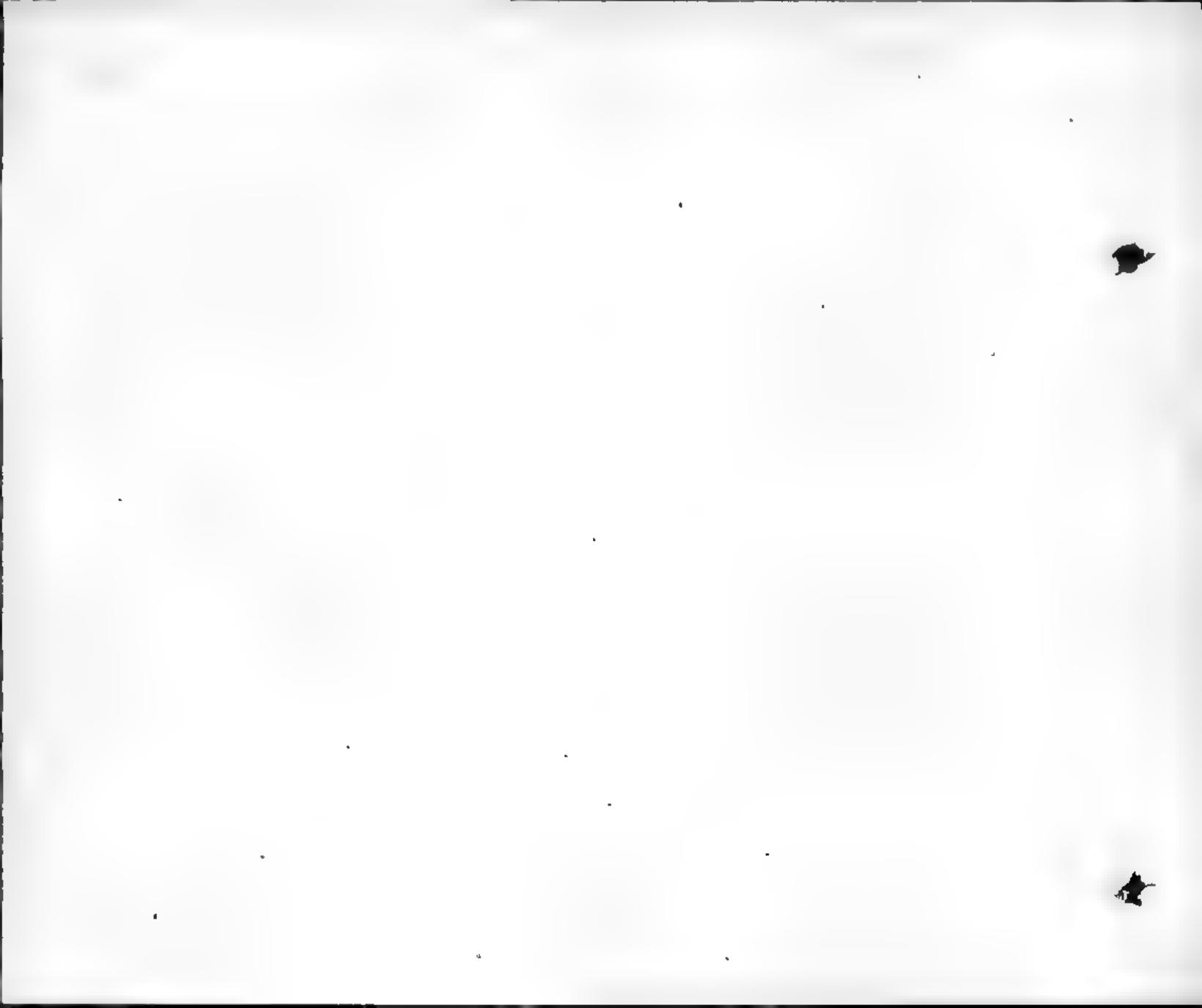
VS ATS 41
ISM 9 5B

1. PLACE OF DEATH a. COUNTY <u>CECIL</u>		2. USUAL RESIDENCE (Where deceased lived) <input checked="" type="checkbox"/> institution. Residence before admission a. STATE <u>MD.</u>	
b. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town) <u>EINTON</u>		b. COUNTY <u>CECIL</u>	
c. LENGTH OF STAY IN lb <u>2 WEEKS</u>		c. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town) <u>PERRYVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION Hospital</u>		d. STREET ADDRESS <u>1 BROAD STREET</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jeanie</u>	Middle <u>Middle</u>	4. DATE OF DEATH <u>LATE</u>	Month <u>11</u> Day <u>5</u> Year <u>1961</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/5/1911</u>
9. AGE (In years less than birthday) <u>75</u>	10. USUAL OCCUPATION Give kind of work done during most of working life even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u></u>	11. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Willie Glasgow</u>	14. MOTHER'S MAIDEN NAME <u>Mae Hall</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>NO</u> (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>18</u>	INFORMANT <u>Louis LACE</u>	Address <u>PERRYVILLE, MD</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>EDEMA OF LULS & VISCERA</u> DUE TO Condens, if any which gave rise to immediate cause (a), stating the under- lying cause (a) <u>(b) CEREBRAL VASCULAR ACCIDENT</u> DUE TO (c) <u>HYPERTENSIVE ARTERIOSCLEROTIC DISEASE 10 YEARS</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVING IN PART I. <u>2 WEEKS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>Day</u> Year <u>Hour</u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home farm factory, street, office bldg., etc.)		20f. (City or town) <u>10/23/1961</u> to <u>11/5/1961</u> (County) <u>10/23/1961</u> to <u>11/5/1961</u> (State) <u>MD.</u>	
21. I certify that I attended the deceased from <u>11/5/1961</u> and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>201 E. MAIN ST</u> DATE SIGNED <u>11/14/61</u>			
ACTUAL SIGNATURE <u>Randall Ross</u>	22. BLR. A. CREMATION, DATE THEREOF <u>BURIAL 11/7/61</u> 22c. NAME OF CEMETERY OR CREMATORIAL <u>Woodland Cemetery Ashland</u> 22d. LOCATION (City, town, or county) <u>Virginia</u> (State)		
PHYSICIAN'S NAME (Type) <u>RANDALL ROSS, M.D.</u>	23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hickey, EINTON, MD</u> ADDRESS <u>11/14/61</u> 24a. REC'D BY REGISTRAR <u>DATE</u> 24b. REGISTRAR'S SIGNATURE <u>11/14/61</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the attending physician or by the funeral director if the deceased has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remove carbon paper. Page 1 and 2 should be used with page 3. Please remove carbon paper. Page 1 and 2 should be used with page 3. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL c. LENGTH OF STAY IN TB 81 yrs d. NAME OF HOSPITAL (If not in hospital, give street address or institution) Marley Hospital				2. USUAL RESIDENCE (Where deceased resided if institution, Residence before admission) a. STATE MD b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural El. 21 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				Reg. No. 12535			
3. NAME OF DECEASED First CHARLES Middle WINTON Last MARLEY SR. (Type or print)				4. DATE OF DEATH Nov. 21, 1961				Month Nov. Day 21 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 2, 1881		9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR (If under 24 hrs) Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most or working life, even if retired) Actor				10b. KIND OF BUSINESS OR INDUSTRY Marine				11. BIRTHPLACE (State or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Luke Marley				14. MOTHER'S MAIDEN NAME Mc Info.							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None				INFORMANT Charles W. Marley, Jr. Wilm. Del. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 49IX Conditions if any which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO (b) DUE TO (c)											
BILATERAL BRONCHOPNEUMONITIS ACUTE BACTERIAL U.R.T. INTERVAL BETWEEN ONSET AND DEATH 3 weeks 1 week?											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Congest. Heart Disease											
20a. IF DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)											
20b. TIME OF INJURY Month Nov. Day 21 Year 1961 Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1521 W. MAIN (City or town) Elkton, Md. (County) Md. (State) Md.											
21. I certify that I attended the deceased from 10/16/61 to 11/6/61 , 1961 that I last saw the deceased alive on 11/6/61 and that death occurred on 11/6/61 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1521 W. MAIN DATE SIGNED 11/6/61											
ACTUAL SIGNATURE PETER STAVRANIS M.D. PHYSICIAN'S NAME (Type) PETER STAVRANIS M.D.											
22a. B. R. A. CREMATION REMOVAL (Specify) None		22b. DATE THEREOF Nov. 7, 1961		22c. NAME OF CEMETERY OR CREMATORIUM Gilpin Manor Memorial Park		22d. LOCATION (City, town, or county) Elkton, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE PIPEY FUNERAL HOME ADDRESS Elkton, Md.											
24a. REC'D BY REGISTRAR NOV 9 1961 DATE						24b. REGISTRAR'S SIGNATURE John S. Harlan					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

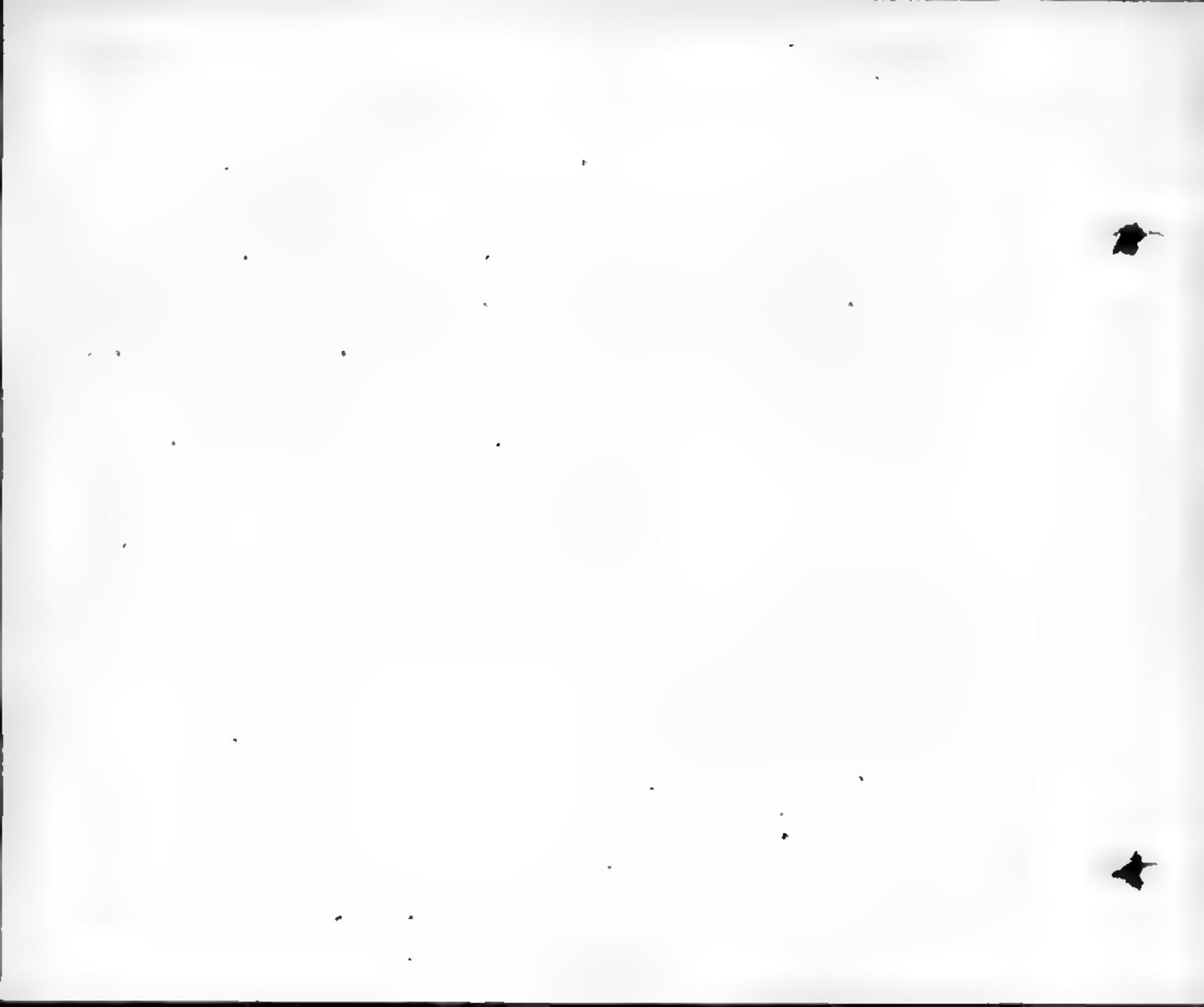
Item 2 from birth certificate

CERTIFICATE OF DEATH

Reg. No. 12521

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with the registrar prior to burial, cremation or removal. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

12536		2 USUAL RESIDENCE (Where deceased lived, if not in town, Residence before admission)	
1 PLACE OF DEATH a. COUNTY Cecil		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		b. LENGTH OF STAY IN 20 yrs.	
c. CITY OR TOWN, If outside corporate limits, write RURAL and give nearest town) Glasgow		c. LENGTH OF STAY IN XX	
d. NAME OF HOSPITAL (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS XX Brigitta Mobile Home	
e. DATE OF DEATH Nov. 11, 1961		e. RESIDENCE ON A FARM? NO	
3 NAME OF DECEASED (Type or print) Jodi		First Middle Last Lynne Mc Nair	
4 DATE OF DEATH Nov. 11, 1961		Month Nov.	
5 SEX Female		6. COLOR OR RACE White	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 13, 1961	
WIDOWED <input type="checkbox"/>		9. AGE in years last birthday yrs	
DIVORCED <input type="checkbox"/>		10. IN JUDGMENT OF 11. BIRTHPLACE (State or foreign country) Elkton, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joe Michael Mc Nair	
14. MOTHER'S MAID NAME Judith Ellen Van Keuren		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOC. SEC. NUMBER none		17. INFORMANT Joe M. Mc Nair, Glasgow, Del.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 765-21 DUE TO acute respiratory failure Conditions if any which gave rise to immediate cause (b) (c) DUE TO Cerebral anoxia Subarachnoid hemorrhage		19. INTERVAL BETWEEN ONSET AND DEATH 12 hours 27 hours ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/13 1961 to 11/14 1961 that I last saw the deceased alive on 11/14 1961 and that death occurred at 4:35 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state)		DATE SIGNED 11/15/61	
ACTUAL SIGNATURE <i>Peter Stavrakis</i>		PHYSICIAN'S NAME (Type) Peter Stavrakis, M.D.	
22a. FUNERAL REMOVAL (Specify) Pippin		22b. DATE THEREOF 11-17-61	
22c. NAME OF CEMETERY OR CREMATORIUM Gilpin Manor Mem. Pk.		22d. LOCATION City, town, or county Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS Donald L. Pippin, Elkton, Md.	
24a. REC'D. BY REGISTRAR Date NOV 20 '61		24b. REGISTRAR'S SIGNATURE S. Thomas	



1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12534

MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12525

1. PLACE OF DEATH
a. COUNTY

Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Elkton

c. LENGTH OF STAY IN HOSPITAL
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Union Hospital of Cecil County

MARYLAND

DOA

3. NAME OF
DECEASED
(Type or print)

First

Middle

Mosser

4. SEX

b. COLOR OR RACE

Male

White

10a. U.S. OCCUPATION (Give kind of work
done during most of working life, even if retired)

retired carpenter

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

4-2-1890

9. AGE (in years
last birthday)

71 yr.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penna.

13. FATHER'S NAME

William Joseph Mosser

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war record or service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

139-20-0230

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Acute Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH
5 min.

Conditions, if any, which
gave rise to immediate cause
(a), listing the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

General Arteriosclerosis

15 yrs.

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH

20c. TIME OF INJURY
Month Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

R. C. Dodson

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

11/25/61

22c. NAME OF CEMETERY OR CREMATORIUM

LAWN CROFT

23. FUNERAL DIRECTOR

ADDRESS

EGERTON,
Md.

DATE

24a. REC'D BY REGISTRAR

NOV 22 '61

DATE

24b. REGISTRAR'S SIGNATURE

John S. Thomas

1. MEDICAL DIRECTOR: This certificate should be executed within 24 hours after death. Any delay is necessary
to execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM
5M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. If death occurs in a hospital or attending physician may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12538

CERTIFICATE OF DEATH

12526

PLACE OF DEATH

a. COUNTY
Cecil

b. CITY OR TOWN (If out of corporate limits
write, e.g., Ararat, and give nearest town)

Port Deposit

c. LENGTH OF STAY IN 1b

15 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Mt. Ararat Farms

3. NAME OF
DECEASED
Type of print

First
Ann

Middle
Celyne

Last
MOTT

4. DATE
OF
DEATH

Nov. 24 11/ 19 61

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female

White

WIDOWED

DIVORCED

May 2, 1917

9. AGE in years IF UNDER 1 YEAR IF UNDER 24 HRS.
Last birthday Months Days Hours Min.

44 yrs

10a. U.S. OCCUPATION Give kind of work
done during past 6 months if ever employed

house wife

10b. KIND OF BUSINESS OR INDUSTRY II. BIRTHPLACE County & State & foreign country

Own Home

12. CITIZEN OF WHAT COUNTRY

Pennsylvania

U.S.A.

13. FATHER'S NAME

Albert

Ramson

Lukens

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, No, or Unknown) If yes give rank date of service:

No

16. SOCIAL SEC. RTY. NO. 17. INFORMANT

Address

R.F.D.

186-07-2407. Frederick B. Mott, Port Deposit, Md.

INTERVAL BETWEEN
ONSET AND DEATH

2 months

18. CAUSE OF DEATH Enter only one cause per line for a, b and c

PART DEATH WAS CAUSED BY
IMMEDIATE CAUSE IS

4720 a. Conditions, if any, which
gave rise to immediate cause
b. stating the underlying
cause if any

DUE TO

b. DUE TO

c. DUE TO

Coronary Occlusion

Gleno-cig. d. Autonomic sclerosis

& hypertension

19. WAS AN AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of Form 18

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY Home, farm
factory, street, office bldg., etc.

20f. CITY OR TOWN

(County)

State

21. I certify that I (the physician) attended the deceased from 6-21, 1962 to 11-24, 1964, that (I) (we) last saw the deceased alive on 11-23, 1961, and that death occurred at 2 AM, from the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

G.H. Richards Jr. M.D.

22b. DATE
SIGNED

Wade

23a. BURIAL, CREMATION OR
REMOVAL (Specify)
Burial

11-27-1961

23c. NAME OF CEMETERY OR CREMATORIUM

ADDRESS

23d. LOCATION (City, town or county)

(State)

Hopewell Cemetery Port Deposit, Md. Rural

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE

25a. REC'D. BY REGISTRAR

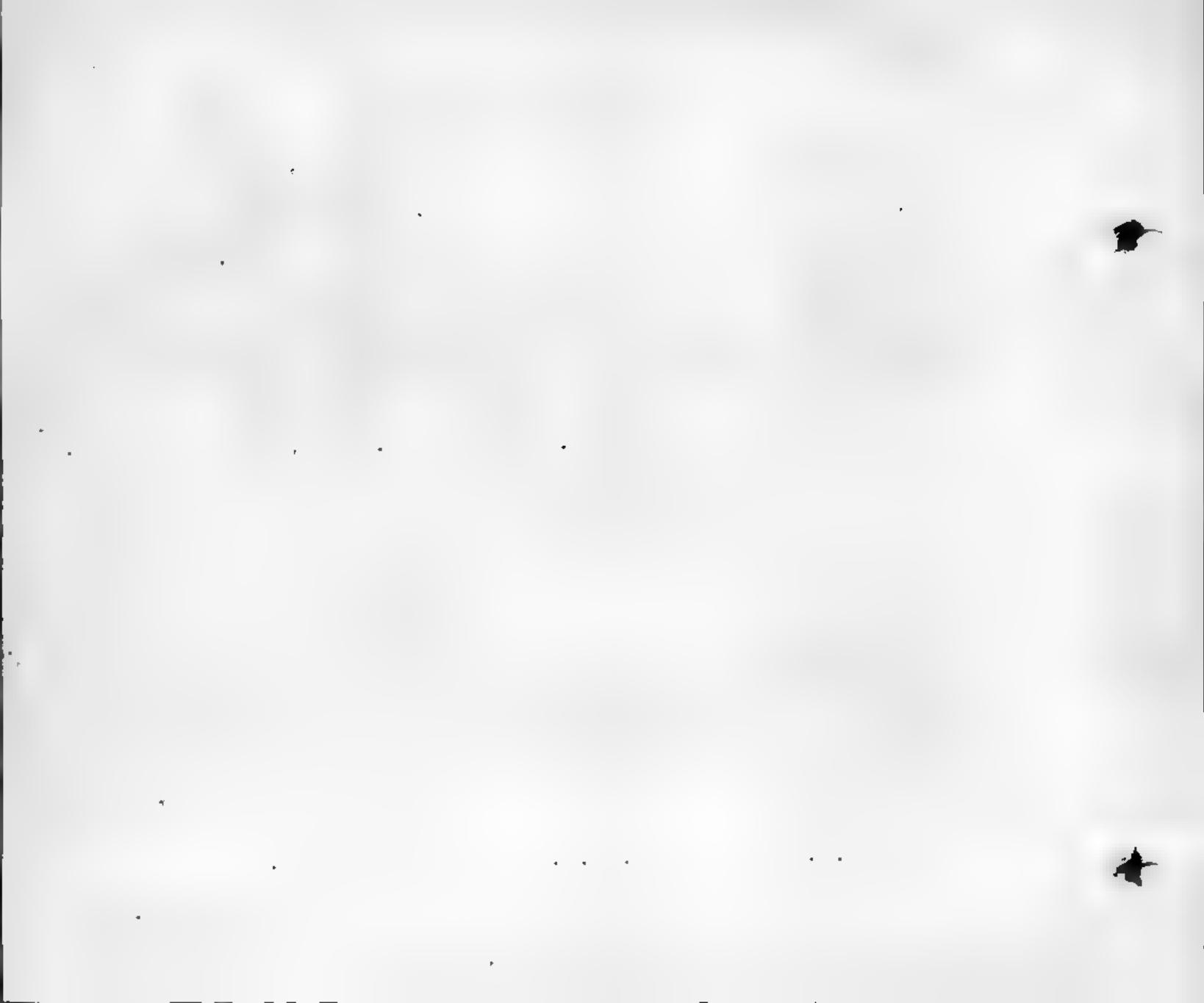
DATE

25b. REGISTRAR'S SIGNATURE

DATE

NOV 28 '61

Arthur L. Thomas



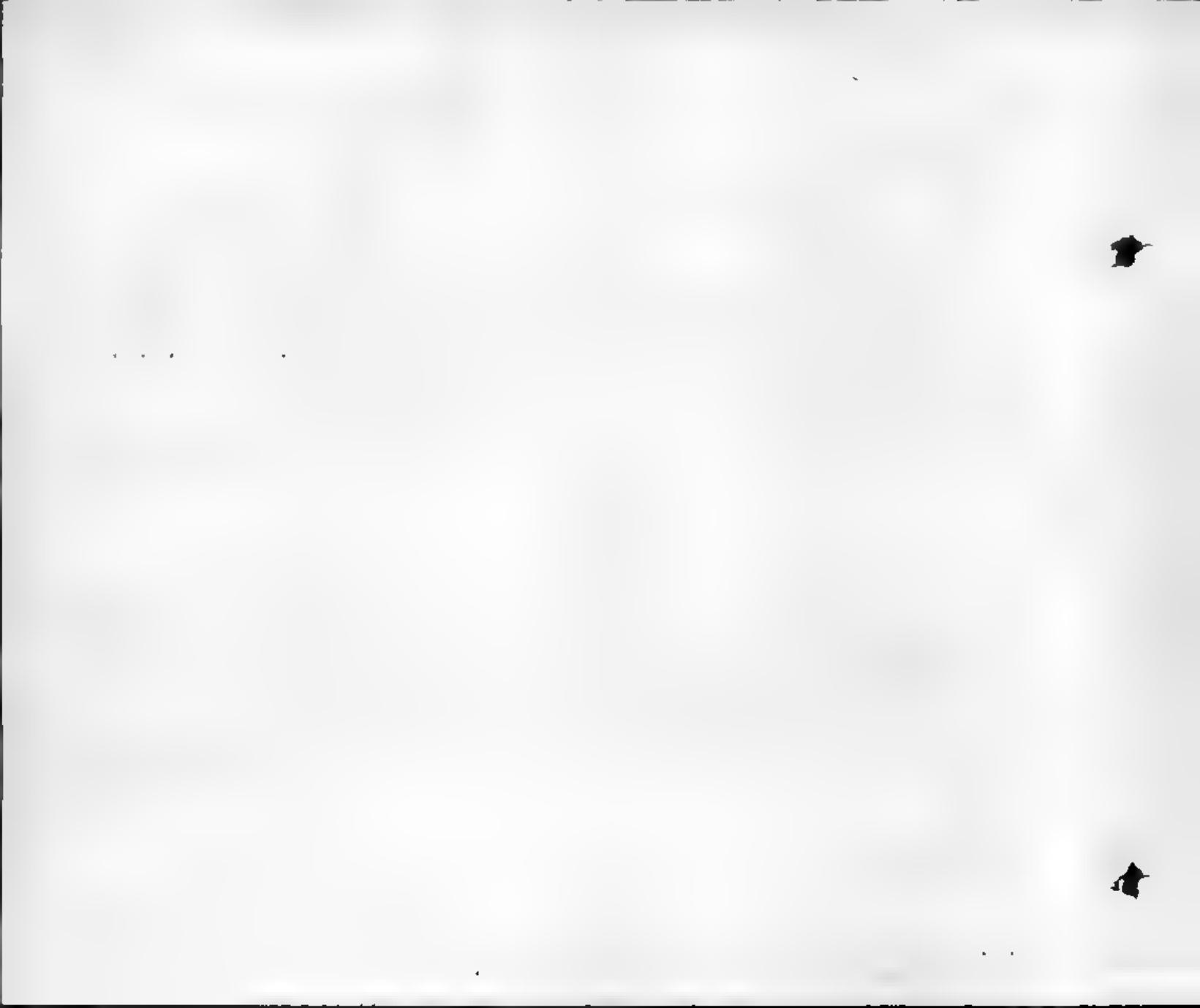
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12539

CERTIFICATE OF DEATH

Reg. Dist. No. 12527

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased resided if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		b. COUNTY Cecil	
c. LENGTH OF STAY IN 1b Union Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Carl	Middle D.	Last Muller
4. DATE OF DEATH	Month Nov.	Day 14	Year 1961
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30/1899
9. AGE (In years at death) 62 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commercial Artist		10b. KIND OF BUSINESS OR INDUSTRY Retired	
10c. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		11. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Daniel Muller		14. MOTHER'S MAIDEN NAME Elizabeth Muhe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No		16. SOCIAL SECURITY NO 216 03 4612	
17. INFORMANT		Address Robert C. Muller, 44 Chippendale Circle, Newark, Delaware	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) complications of multiple sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 12 yrs.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/15/61</u> to <u>11/14/61</u> , that I last saw the deceased alive on <u>11/13/61</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Rising Sun, Md.	
ACTUAL SIGNATURE <i>Neil Taylor Jr.</i>		DATE SIGNED 11/14/61	
PHYSICIAN'S NAME (Type) <i>Neil Taylor Jr.</i>		Rising Sun, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/1961	
22c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Park		22d. LOCATION (City, town, or county) Balto. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.		24a. REC'D BY REGISTRAR MAY 17 1961	
		24b. REGISTRAR'S SIGNATURE Neil Taylor Jr.	



1
FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: This cert'cate should be executed within 24 hours after death. If any delay is necessary, please forward the certificate, writing the word "pending", a pencil, in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form PMJ. Page 5 may be retained for your files or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12525

1. PLACE OF DEATH

b. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Elkton

c. LENGTH OF STAY IN FB

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Union Hospital

NAME OF
DECEDERED
(Type or print)

First

Middle

KYLE

MULLINS

5. SEX

6. COLOR OR RACE

Male

White

10a. USWA OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Plastic

11. BIRTHPLACE (State or foreign country)

Paynesville, W. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Harvey Mullins

14. MOTHER'S MAIDEN NAME

Viola Blankership

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes give war and date of service)

17. INFORMANT

Address

220-34-6807 Wm. H. Mullins, Elkton, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Fractures Skull and neck

11/14

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

5 min.

19. WAS AUTOPSY PERFORMED? YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

Car turned over after cutting off of telephone Pole

20c. TIME OF INJURY Month, Day, Year

Hour

20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town) County, (State)

Min.

at work at work at work

Rt. 274 North East R.D. Cecil Co., Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

R. C. Dodson, M.D.

CHIEF MEDICAL EXAMINER

EXAMINER'S
NAME (Type)

22a. DATE THEREOF

REMOVAL (Specify)

Funeral

23. FUNERAL DIRECTOR

11-8-61

22c. NAME OF CEMETERY OR CRÉMATORI

Vance Cemetery

ADDRESS

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

ADDRESS (City, town, or county)

22d. LOCATION (City, town, or county)

Paynesville, W. Va. (State)

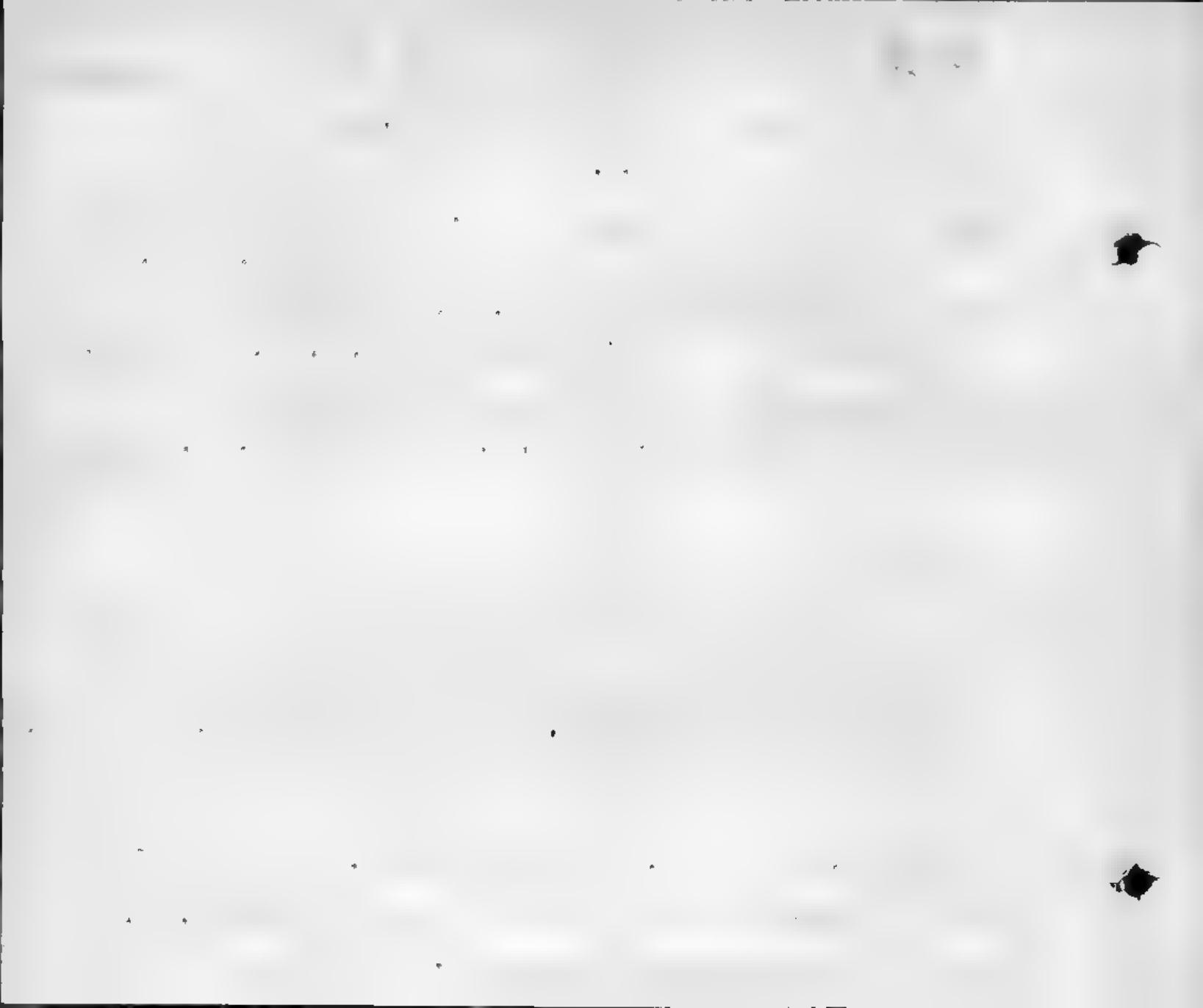
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE SIGNED

11-5-61

PIPPIN FUNERAL HOME Donald M. Elton, Md. DECEASED NOV 9 '61
VS A15ME
SM 9 60
11-5-61
in care of Elton



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12541

CERTIFICATE OF DEATH

Reg. Dis. 12529

1. PLACE OF DEATH
a. COUNTY

Cecil

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE

Md.

b. COUNTY

Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bohemia Manor

c. LENGTH OF STAY IN 1b

RURAL and give nearest town

d. NAME OF HOSPITAL, if not in hospital, give street address
OR INSTITUTION

Bohemia Manor, near Chesapeake City,

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
Edna

Middle

Last

4

DATE
OF
DEATHMonth
Nov.Day
27Year
1961

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE
IN YEARS
(last birthday)

85

IF UNDER 1 YEAR
MonthsIF UNDER 24 HRS
Days

Hours

Min

Female

Negro

WIDOWED DIVORCED

March 3, 1876

10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

II

BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Minor Washington

14. MOTHER'S MAIDEN NAME

Kate-?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, No, or unknown)

(If yes, give year or dates of service)

16. SOC. SEC. SECURITY NO.

INFORMANT

Address

213-01-1164- Lola Nuble, Bohemia Manor, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Uremia with cerebral thrombosis

INTERVAL BETWEEN
ONSET AND DEATH
2 days.

446X

Conditions if any which
gave rise to immediate
cause (a), stating the under-
lying cause last

DUE TO

(b)

Neprosclerosis

years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAMED SEASIDE CONDITION GIVEN IN PART I a

Senility

9. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month Day Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY Home farm 20f. (City or town)
factory, street, office bldg. etc.

County

(State)

21. I certify that I attended the deceased from Nov 25, 1961 to Nov 27, 1961, that I last saw the deceased
alive on Nov 27, 1961, and that death occurred at 2AM M. from the causes and on the date stated above
ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Wallace Obenshain

MD

Cecilton, Md.

28 Nov 61

PHYSICIAN'S
NAME (Type)

Wallace Obenshain, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 12/2/6122b. DATE THEREOF
Ebenezer Cem.

22c. NAME OF CEMETERY OR CREMATORIUM

(State)

Bohemia Manor, Md.

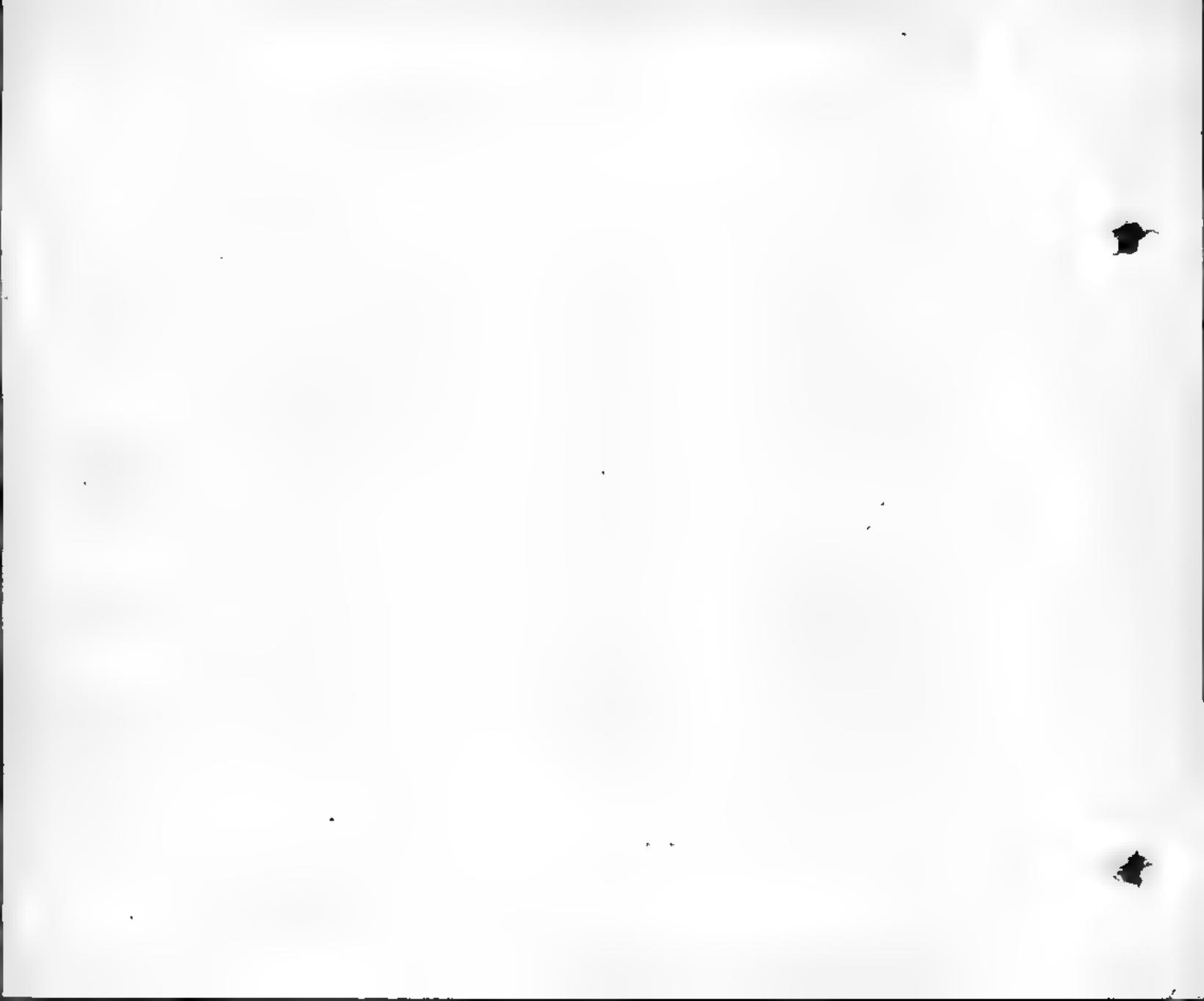
23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Wilm.

24a. REC'D BY REGISTRAR
DATE NOV 30 '61

24b. REGISTRAR'S SIGNATURE





TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 72 hours after death. Page 4
 may be signed by the hospital or attending physician or by the funeral director. After the certificate has been signed by the attending physician or by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers, and 2 should be used with the register prior to burial, cremation or removal and in any event within 72 hours after death.

1

3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12543

CERTIFICATE OF DEATH

Reg. No. 12531

1 PLACE OF DEATH a. COUNTY Cecil		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md. Cecil b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City	
3. NAME OF DECEASED (Type or print) MARTHA		First CLINTON	Middle PENSEL
4. DATE OF DEATH Nov.		Month 19	Day 19
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 10, 1879		9. AGE in years 82 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Warwick, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Clinton Lynch	
14. MOTHER'S MAIDEN NAME Catherine Caldwell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) no	
16. SOCIAL SECURITY NO none		17. INFORMANT Henry J. Pensel, Chesapeake City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Condit. ans. if any which gave rise to immediate cause (a), stating the under- lying cause (b) DUE TO b) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE DUE TO c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct</u> 19, 1961, to <u>Nov. 19, 1961</u> , that I last saw the deceased alive on <u>Nov. 19, 1961</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above ACTUAL SIGNATURE HENRY V. DAVIS MD PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) CHESAPEAKE CITY, MD DATE SIGNED 11/19/61	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-61	22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery
22d. LOCATION (City, town or county) Md.		22e. REG. BY REGISTRAR NOV 22 1961	
23. FUNERAL DIRECTOR'S SIGNATURE P. I. IN FUNERAL HOME Elkton		24b. REGISTRAR'S SIGNATURE Elkton & Sons	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12544

CERTIFICATE OF DEATH

Reg. Dist. No. 12532

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death
 may be made by the hospital or attending physician
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial or cremation or removal and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle H.	Last Pyle
4. DATE OF DEATH November 18 1961	Month November	Day 18	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1883
9. AGE in years (last birthday) 78 yrs	10. KIND OF BUSINESS OR INDUSTRY Fisher	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William C. Pyle		14. MOTHER'S MAIDEN NAME Agnes Potridge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO None	INFORMANT George Pyle Chesapeake City, Md.
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 Conditions if any which gave rise to immediate cause (a), stating the under- lying cause last b. DUE TO c. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days year	
M. S. encephalitis Generalized Arthritis			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY Home, farm, 20f. City or town) factory, street, office bldg. etc.) (County) (State)
21. I certify that I attended the deceased from 13 Nov. 1961 to 18 Nov. 1961, that I last saw the deceased alive on 18 Nov. 1961, and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Wallace Obenshain M.D. 21 Nov. 1961			
PHYSICIAN'S NAME (Type)		Wallace Obenshain Cecilton, Md.	
22a. FUNERAL DIRECTOR'S SIGNATURE	22b. DATE THEREOF Nov. 22, 1961	22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery	22d. LOCATION (City, town, or county) Md. Chesapeake City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE TOMMY FLETCHER, INC.		24a. ADDRESS Davidson Elkton, Md.	24b. DATE REC'D BY REGISTRAR NOV 22 '61
		24c. REGISTRAR'S SIGNATURE C. M. & T. Inc.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1B

12545

CERTIFICATE OF DEATH

12545
Rec'd. No.

1. PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN		b. COUNTY CECIL			
c. LENGTH OF STAY IN 1b 73 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS S. QUEEN			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First CURTIS	Middle SPENCER	Last REYNOLDS		
4. DATE OF DEATH	Month NOVEMBER	Day 15	Year 1961		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1888		
9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER	10b. KIND OF BUSINESS OR INDUSTRY GENERAL PAINTING	11. BIRTHPLACE (State or foreign country) RISING SUN, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE C. REYNOLDS	14. MOTHER'S MAIDEN NAME LAURA SPENCER	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (If yes, give rank and date of service) W.W.I	16. SOCIAL SECURITY NO 220-07-4998	17. INFORMANT Mrs Mildred Tifford, Elton, Md.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4-0-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. b. DUE TO c. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)	INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) Rising Sun	(County) Cecil Co.	(State) Md.
21. I certify that I attended the deceased from 8/15/1961 to 11/15/1961, that I last saw the deceased alive on 11/10/1961, and that death occurred at 8 A.M. from the causes and on the date stated above	ADDRESS (Street, city or town, state) Rising Sun, Md.		DATE SIGNED 11/16/61		
ACTUAL SIGNATURE Neil R Taylor	PHYSICIAN'S NAME (Type) Neil R Taylor Jr. M.D.				
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/18/1961	22c. NAME OF CEMETERY OR CREMATORIUM Brookview Cemetery	22d. LOCATION (City, town, or county) Rising Sun, Cecil Co., Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M Reed, Rising Sun, Md.	ADDRESS	24. REC'D BY REGISTRAR DATE NOV 20 '61	24b. REGISTRAR'S SIGNATURE Rising Sun		



1
FOR STATE
HEALTH DEPT.

4
TO FUNERAL DIRECTOR: This certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be filed with the State Board of Health.
5
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.
6
or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

12-076 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12531

1. PLACE OF DEATH
a. COUNTY

CECIL

b. CITY OR TOWN (Outside corporate limits, write RURAL and give nearest town)

Elkton

c. LENGTH OF STAY IN 16

MARYLAND

D.O.B.

2. USUAL RESIDENCE Where deceased lived, if institution Residence before admission

a. STATE

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

MD.

CECIL

RISING SUN

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day Year

WALTER

HERBERT

REYNOLDS

11/

22/ 1961

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

M.

W.

WIDOWED

DIVORCED

9. AGE in years
(last birthday)

10. USUAL OCCUPATION Give kind of work
done during most of working life, even if retired

11. IF UNDER 1 YEAR

12. IF UNDER 24 HRS

13. CITIZEN OF WHAT COUNTRY

Machine Operator Cable Plant

14. MOTHER'S MAIDEN NAME

U.S.A.

Horace J. Reynolds

Ruby Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unknown) (If yes, give rank or date of service)

16. SOCIAL SECURITY NO

17. INFORMANT

Address

No 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

2 3 X DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first } (b) } DUE TO
} (c) }

Fracture of right fibula and Tibia compounded
Fracture of neck abrasion both legs left side of
forehead Laceration of scalp 2½ in long and 1½ in long.

INTERVAL BETWEEN
ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

Car wrecked and he was hit by a tree.

20c. TIME OF INJURY Month Day Year
Hour Min. 11 22 61

20d. INJURY OCCURRED 20e. PLACE OF INJURY Home, farm,
factory, tree, office bldg, etc.)

20f. CITY or town, County, (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

R.C. Dodson

EXAMINER'S
NAME Type

22a. BUR. A. CREMAT. ON: 22b. DATE THEREOF

REMOVAL (Specify)

Burial 11/26/61

23. FUNERAL DIRECTOR

Ermon E. McMullen

22c. NAME OF CEMETERY OR CREMATORIUM

ADDRESS

22d. LOCATION (City, town, or country)

(State)

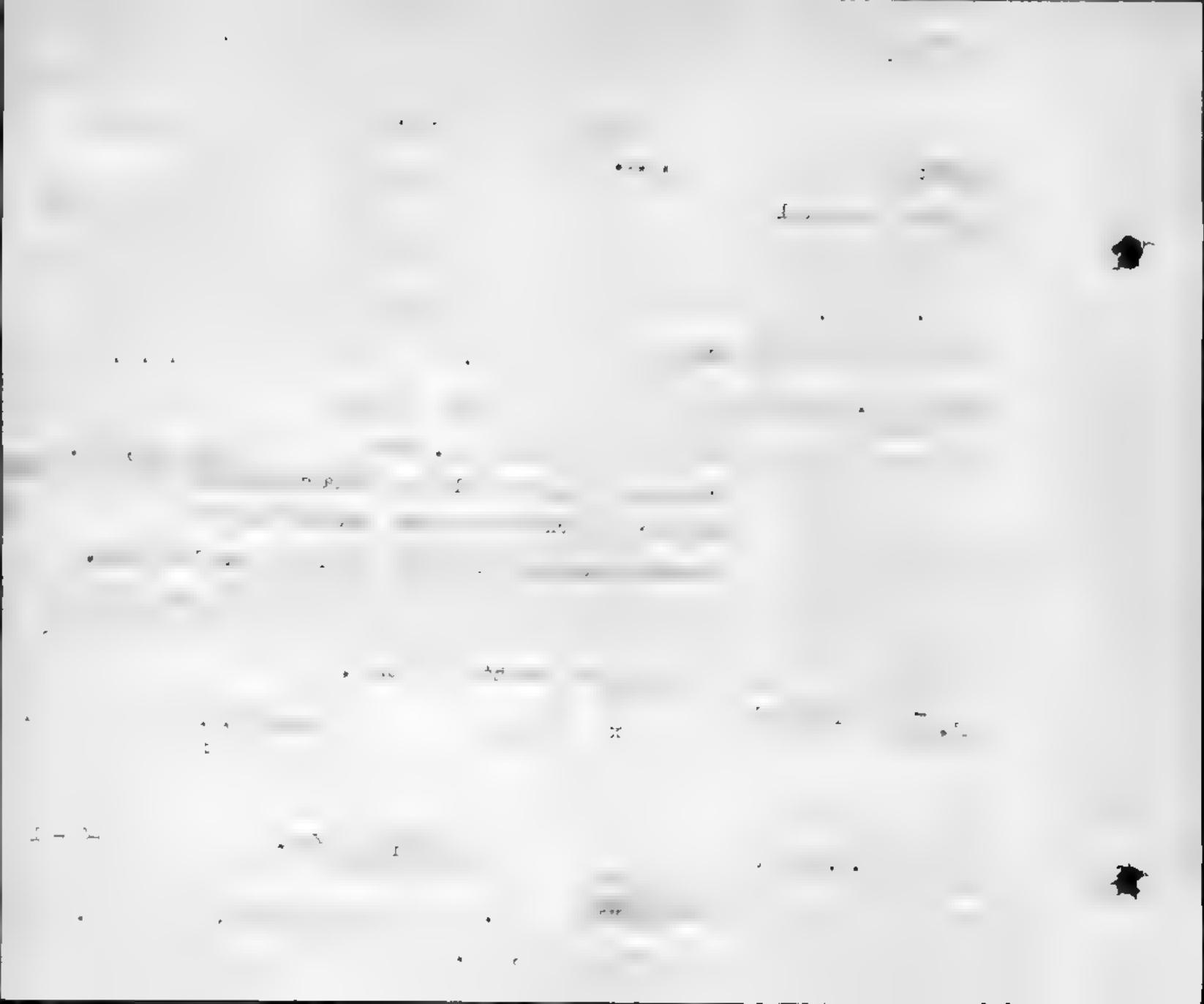
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Rising Sun, Md. DATE NOV 27 '61

Ermon E. McMullen

VS. AISM
SM 9 40



1
FOR STATE
HEALTH DEPT.

Pls. secure the cert. file, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMJ. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit file. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Item 2G File # 1
11-7-71 am

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12047 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12535

1. PLACE OF DEATH
a. COUNTY

CECIL

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Perryville

d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address)

V.A. Perry Point, Md.

3. NAME OF
DECEASED
(Type or print)

Fructuoso RIVERA

5. SEX

Male

White

10a. USUAL OCCUPATION (Give kind of work
done during most of working life even if retired)

Machine Operator

13. FATHER'S NAME

Bicente Rivera

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service)

Yes Korean

16. SOCIAL SECURITY NO. 17. INFORMANT

457-44-7890 V.A. Hospital Records-Perry Point, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

929.9 DUE TO

Conditions, if any which
gave rise to immediate cause

(b) DUE TO

(c) stating the underlying
cause (d)

Suffocation

Accidental Drowning

INTERVAL BETWEEN
ONSET AND DEATH

1 Hr.

1 Hr.

MEDICAL CERTIFICATION

21. I certify that I took charge of the remains described above, held an Autopsy inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

20a. EXTERNAL CAUSE WAS

PRIMARY or CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of Item 18.

Caught foot in board over ditch & fell and unable to

raise head out of water

20c. TIME OF INJURY Month Day Year

Hour p.m.

-

19

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm

factory, street, office bldg., etc.)

20f. (City or town)

County

(State)

While at work at work

at work at work

ACTUAL
SIGNATURE

R. S. DODSON

EXAMINER'S
NAME, Type

R. S. Dodson

22a. BUR AL CREMATION 22b. DATE THEREOF

REMOVAL (Specify)

Removal

11/11/61

22c. NAME OF CEMETERY OR CREMATORY

Baltimore National

ADDRESS

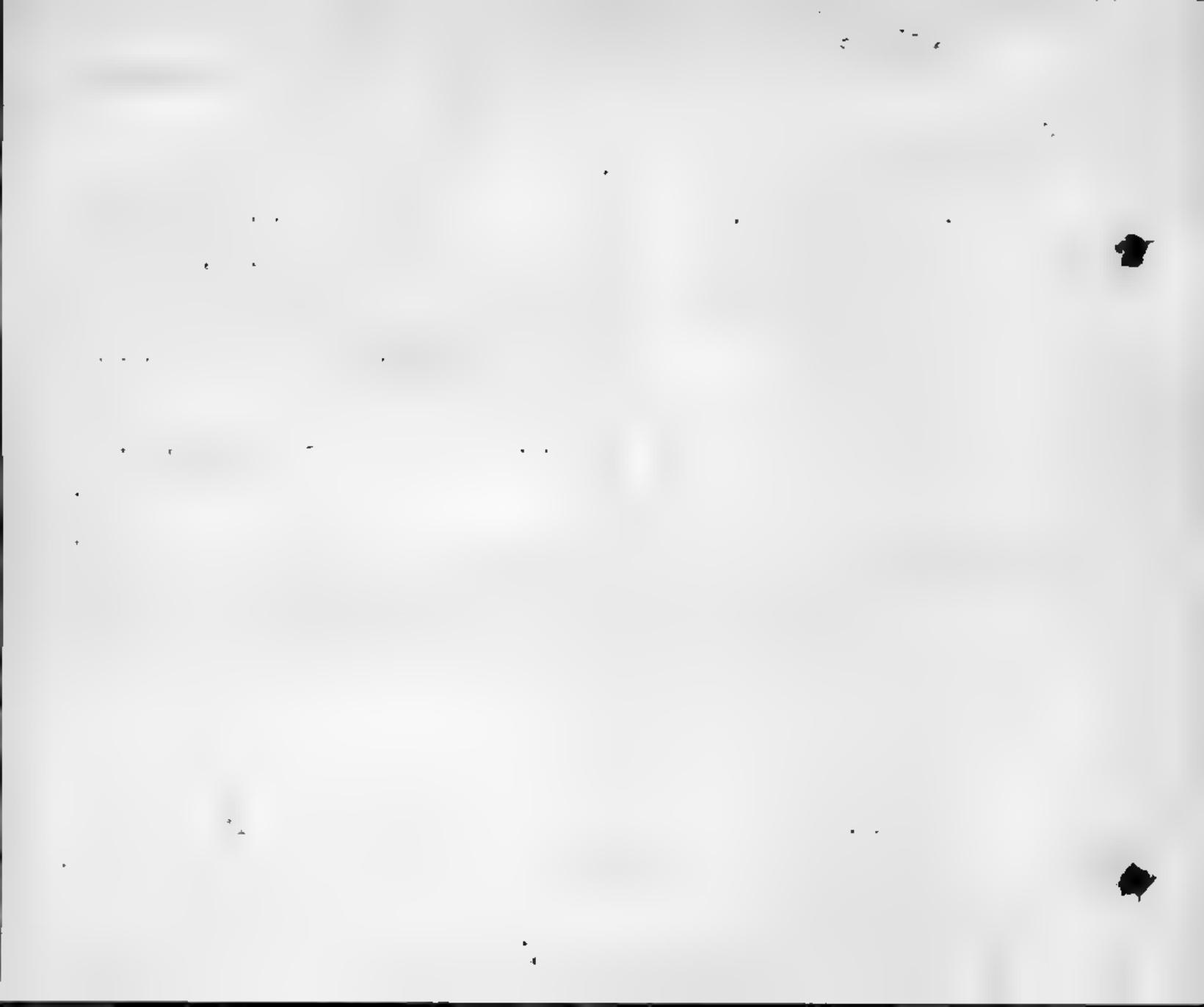
24a. REC'D BY REGISTRAR

NOV 20 '61

24b. REGISTRAR'S SIGNATURE

Charles E. Hause

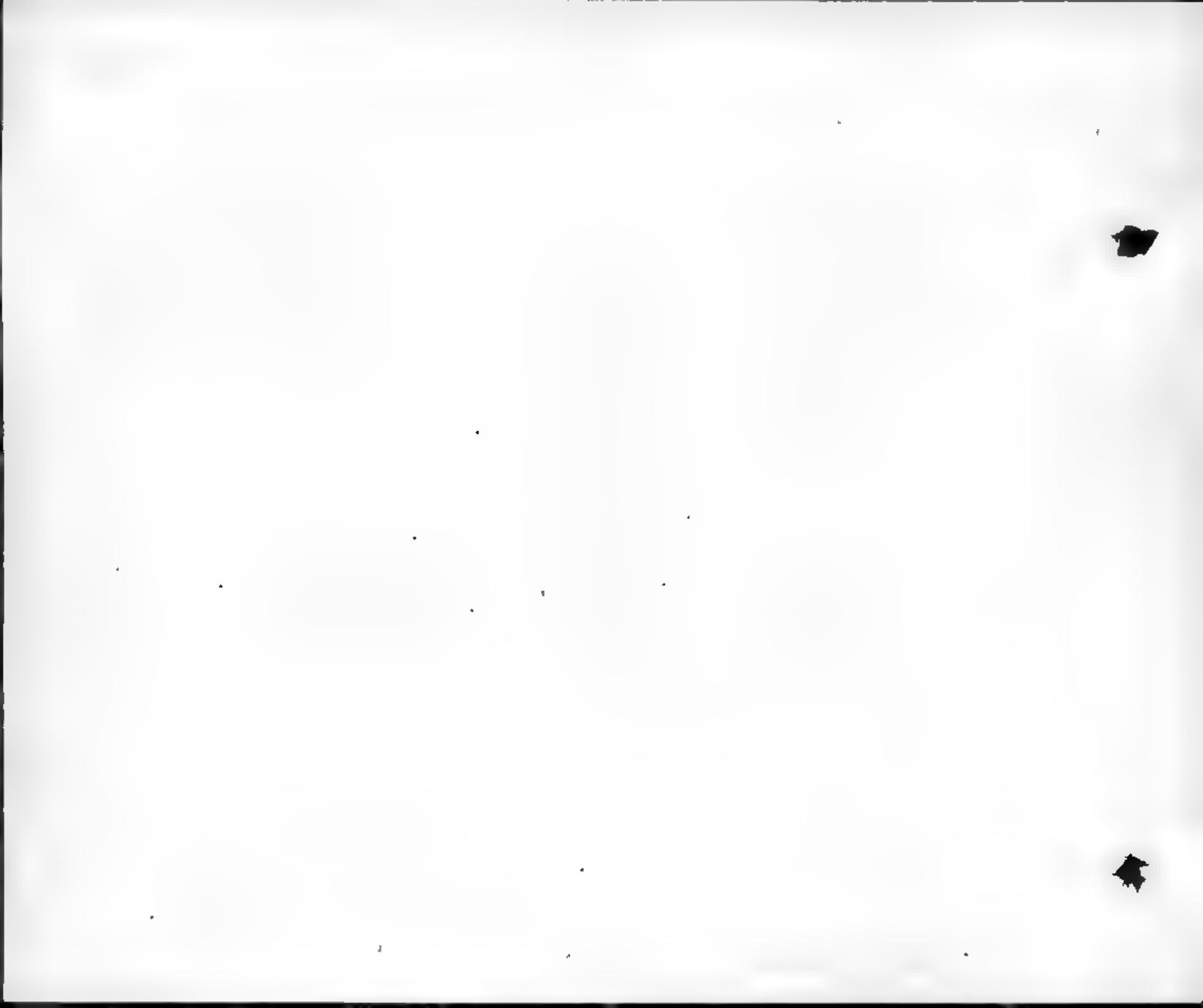
VS. ATSM
SM 9-60



14
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 72 hours after death
15
MO. OF DEATH
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be used with page 3.

12548 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg 60536

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>	2. USUAL RESIDENCE Where deceased lived if not in institution. Residence before admission a. STATE <i>Md.</i>						
b. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town <i>Lester</i>	c. LENGTH OF STAY IN 1b <i>Lester</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Lester</i>	d. STREET ADDRESS <i>10005</i>						
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Earl</i>	Middle <i>S</i>	Last <i>Roark</i>	4. DATE OF DEATH <i>12/6/61</i>	Month <i>11</i>	Day <i>2</i>	Year <i>1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>12/6/01</i>	8. AGE (In years last birthday) <i>59 yrs.</i>	9. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION Give kind of work done during most of working life even if retired <i>Chemical Plant</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>William M. Roark</i>	14. MOTHER'S MAIDEN NAME <i>Cordelia Lewis</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes no or unknown <i>No</i>	16. SOCIAL SECURITY NO <i>091-01-8702</i>	INFORMANT <i>Mrs. Virginia L. Roark Elkton, Md.</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2-3 weeks</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>502.0</i> DUE TO Conditions, if any, which gave rise to (immediate cause (a), stating the underlying cause lost) <i>(b)</i> DUE TO <i>Chronic pulmonary emphysema</i>		Congestive heart failure		8-10 years			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <i>Pulmonary emphysema bilateral in 1954-1956.</i>		Bronchitis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMNER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>at work</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) <i>Elkton</i>	(County) <i>Md.</i>	(State) <i>Md.</i>		
21. I certify that I attended the deceased from <i>11/6/61</i> to <i>11/12/61</i> , 1961, that I last saw the deceased alive on <i>11/6/61</i> , 1961, and that death occurred at <i>Elkton</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>134-W Main</i>				DATE SIGNED <i>Elkton, Md.</i>	
ACTUAL SIGNATURE <i>Patsy L. Roark</i>	M.D.						
PHYSICIAN'S NAME (Type) <i>ROBERT STARBUCK MD</i>	Elected 1st						
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/6/61</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Gilpin Manor Memorial Park, Elkton, Md.</i>	22d. LOCATION (City, town, or county) <i>Elkton</i>	(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph E. Hicks</i>	ADDRESS <i>Elkton, Md.</i>	24a. REC'D BY REGISTRAR <i>NOV 8 1961</i>	24b. REGISTRAR'S SIGNATURE <i>Chileng & Sons</i>				



12549

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12537

1 PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission, if not in hospital, give street address)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. STATE Md. b. COUNTY Cecil	
c. LENGTH OF STAY IN 1b 2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elk Mills X	
d. NAME OF HOSPITAL OR INSTITUTION Union Hosp.		d. STREET ADDRESS Rural	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Winfield Schuy Simpers	First Winfield	Middle Schuy	Last Simpers
4. DATE OF DEATH 11/19/1961	Month 11	Day 19	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25 1901
10a. S. AL OCCUPATION (Give kind of work done during most of working life even if retired) Machinist	10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George	14. MOTHER'S M AIDEN NAME Annie	15. SETH	Address Elk Mills
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	16. SOCIAL SECURITY NO. 221-07-9008	17. INFORMANT Miss Hanna Simpers	18. INTERVAL BETWEEN ONSET AND DEATH years
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 581/1 DUE TO Laennec's Cardiosis		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b)		DUE TO	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18 if either, notify medical examiner) Chronic pyelonephritis			
20c. TIME OF INJURY Month, Day Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg. etc.)
20f. (City or town) Elk Mills		(County) Md. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from August 1961 to 11-19-1961 that (I) (we) last saw the deceased alive on 11-19-1961 and that death occurred at 24th M. from the causes and on the date stated above			
22a. SIGNATURE Tillman D. Johnson		22b. DATE SIGNED 11-20-61	
22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 123 Sinerly Ave Elkton, Md.
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 11-24-61	
23c. NAME OF CEMETERY OR CREMATORIAL Cherry Hill Cem. Cherry Hill, Md.		23d. LOCATION (City, town or county) Cherry Hill, Md.	
24. ATTENDING-DIRECTOR'S SIGNATURE Vermon E. McMiller		ADDRESS Rising Sun, Md.	
25a. REC'D BY REGISTRAR NOV 22 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. D. 2538

M

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 72 hours after death by the funeral director or by the attending physician. After this certificate has been signed by the attending physician it should be detached for use as the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if not in an institution before admission)		b. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN TB 27 yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION										
3. NAME OF DECEASED (Type or print): Regina		First	Middle	Last	4. DATE OF DEATH Nov.	Month	Day	Year		
5. SEX Female		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1867		9. AGE (in years lost birthday) 54 yrs	10. UNDER 1 YEAR Months	11. UNDER 24 HRS Days	12. UNDER 24 MRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Thomas McEnnis		14. MOTHER'S MAIDEN NAME Margaret Hennessy								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		16. SOCIAL SECURITY NO.		INFORMANT		Address Miss Margaret Spann, North East, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause of death (b) DUE TO Bilateral pneumonia years		19. DUE TO G.A.S., A.S.C.V.D.		20. INTERVAL BETWEEN ONSET AND DEATH 30 min.						
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Senility, Cerebral Art. Sclerosis, Gen. Chr. Rh. Arthritis				22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) Elkton	(County) Maryland	(State) Maryland
21. I certify that I attended the deceased from <u>4-12-1958</u> to <u>11-4-1961</u> at <u>8:20 AM</u> and that death occurred at <u>8:20 AM</u> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Cecil Ave., North East, Md.		
ACTUAL SIGNATURE <i>Luis M. Cuza</i>		PHYSICIAN'S NAME (Type) Luis M. Cuza, M.D.		DATE SIGNED						
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 11-7-61		22c. NAME OF CEMETERY OR CREMATORIUM Immaculate Conception ADDRESS North East, Maryland		22d. LOCATION (City, town or county) Elkton		(State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>						24a. REC'D BY REGISTRAR DATE NOV 9 '61	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kimes</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12551

CERTIFICATE OF DEATH

12539

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 2mo. 21 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS Betterton 14X-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LESLIE (NMI)		First	Middle
		Last	VICKROY
4. DATE OF DEATH November 22 1961		Month	Day
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 12-6-91		9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (retired)		10b. KIND OF BUSINESS OR INDUSTRY Chemical	11. BIRTHPLACE (County & State, or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Not available		14. MOTHER'S MAIDEN NAME Rose Kirby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. None	17. INFOERANT Hospital Records, VAH, Perry Point, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 162-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Bronchogenic carcinoma right upper lobe of lung unknown DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6-7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (A. L. Mooney) attended the deceased from Sept. 1, 1961 to Nov. 22, 1961 and that death occurred on Nov. 20, 1961 from the causes and on the date stated above.		22b. DATE SIGNED 11-22-61	
22a. SIGNATURE A. L. Mooney		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/25/61	23c. NAME OF CEMETERY OR CREMATORIAL Still Pond
23d. LOCATION (City, town or county) Still Pond, Md.		(State)	
24 FUNERAL DIRECTOR'S SIGNATURE Kennedy Funeral Home, Still Pond, Md.		25a. REC'D BY REGISTRAR DATE NOV 27 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MESSI

MESSI

M

MESSI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12552

CERTIFICATE OF DEATH

Reg. Dist. 162540

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union-Elkton, Md.</i>		e. STREET ADDRESS <i>149 Union Street Elkton</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Franklin Taylor Williams</i>		First <i>Franklin</i>	Middle <i>Taylor</i>
4. DATE OF DEATH Month <i>11</i>		5. SEX <i>M</i>	Middle Initial <i>W</i>
6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/15/1893</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>PAPER</i>
10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		11. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Williams</i>		14. MOTHER'S MAIDEN NAME <i>Mary Mason</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>214-01-0389</i>	INFORMANT Address <i>DAVID K. WILLIAMS CHERRY HILL, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Underlying Shin & Elbow of Ings & Ulcer</i>			
DUE TO <i>219X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>	
(b) <i>Peri nephritic distress</i>		DUE TO <i>Unknown</i>	
(c) <i>Tumor of left kidney</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Unknown</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11/10/61</i> to <i>11/17/61</i> that I last saw the deceased alive on <i>11/17/61</i> and that death occurred at <i>Elkton</i> , Md., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>I. Randall Ross</i>		ADDRESS (Street, city or town, state) <i>M.D. 201 E. Main St. Elkton</i>	
PHYSICIAN'S NAME (Type) <i>I. RANDALL ROSS M.D.</i>		DATE SIGNED <i>11/17/61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11/20/61</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>WEST NOTTINGHAM</i>
22d. LOCATION (City, town, or county) <i>WEST NOTTINGHAM, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>PIPPIN FUNERAL HOME</i>		24a. REC'D BY REGISTRAR <i>DATE NOV 22 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Cushing & Associates</i>
ADDRESS <i>Elkton, Md.</i>			

